Proposal for a Section 1915(b) Capitated Waiver Program
Initial Application Preprint

Wisconsin
Family Care
Fond du Lac, Kenosha, LaCrosse,
Portage and Richland Counties

February 2001

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Center for Medicaid and State Operations

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Attachments

* A single set of these attachments is included for the two (b) Waiver applications:
    - for Fond du Lac, Kenosha, LaCrosse, Portage and Richland Counties
    - for Milwaukee County

PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
Initial Waiver Application Form

Introduction

The waiver application form is for a State's use in requesting implementation of a Section 1915(b) waiver program involving Managed Care Organizations (MCOs) or Prepaid Health Plans (PHPs) that provide contracted services to Medicaid enrollees under their care. Section 1915(b) waivers are approved for a period no longer than two years. Generally, a capitated payment rate is paid to the MCO/PHP per enrollee per month for the Medicaid services under the waiver.

The term MCO includes HMOs, organizations with section 1876 or Medicare+Choice contracts, provider sponsored organizations, or any other public or private organization which meets the advance directive requirements, has a risk comprehensive contract, and meets the other requirements of Title XIX of the Social Security Act. PHP includes any entity that provides medical services to enrolled enrollees under contract with the State agency, and on the basis of prepaid capitation fees, but does not have a comprehensive risk contract.

The use of this standardized application form is voluntary. The purpose is to streamline the waiver application process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request a waiver and HCFA's effort to process the waiver proposal.

All waiver requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver application form will help States provide sufficient documentation for HCFA to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) This version of the capitated preprint does not include new requirements proposed for the Medicaid BBA regulation for managed care. Once those regulations are promulgated in their final form, waiver requests will need to document compliance with any new requirements the regulations may contain. (2) States must still have MCO contracts and capitation rates prior approved by their HCFA Regional Office.

HCFA staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting a waiver under only Sections 1915(b)(2), 1915(b)(3, or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their HCFA Regional Office to identify required submission items from

this format. Please note that States must still obtain HCFA Regional Office prior approval of MCO contracts and capitation rates (i.e. that they do not exceed the upper payment limit).

Waiver Submittal Instructions (See State Medicaid Manual 2106)

Please submit an original and four copies of the waiver request to the appropriate office:

For MCO and PCCM programs:

HCFA, Center for Medicaid and State Operations
Attn: Director, FCHPG, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For Prepaid Health Plan programs focusing on Behavioral Health or Elderly and Disabled populations:

HCFA, Center for Medicaid and State Operations
Attn: Director, DEHPG, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

Also, send at least one copy of those requests to the HCFA RO at the same time. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary denies such requests in writing or informs you in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of receipt of your response to the request for additional information, or the waiver request is deemed to have been granted.

The 90-day time period begins (i.e., day number one) on the day the waiver is received by the addressee (i.e., the Secretary, the HCFA administrator, the RO, or the Division of Integrated Health Systems) and ends 90 calendar days later. A new 90-day period begins when the requested information is received, and HCFA must then either approve or disapprove the request.

General Instructions

This streamlined application uses a checklist format. States should check all items which apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

X A number of the items are required by federal statute, regulation, or policy. These

required items are identified as such either in the instructions or headings for a section, or on an item by item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

X All items are applicable to both MCOs and PHPs unless otherwise noted (i.e. only MCO or PHP is referenced in the item)

X For any of the application sections that require explanations, if possible, please insert them into the document itself instead of attaching the explanation as an appendix.

X If there is a check box next to a required item, please mark the box to note the State's compliance with the item.

X If a State modifies the wording of the preprint, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or preprint modification to the standard preprint format.

X Please update the table of contents prior to submitting the waiver to HCFA to reflect the current page numbers and appendices.

X Please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a is the attachment for question a. under point I. Elements of State Quality Strategies in Section C.)

Section A. General Impact

I. Background

Please provide a brief executive summary of the States 1915(b) waiver program, including how it was developed, past experiences with managed care and what input was obtained from outside organizations and third parties (e.g. beneficiaries, advocates, providers, etc.). To the extent the State intends to enroll persons with special health care needs, please describe how the various stakeholders are involved in the development, implementation, and ongoing operation of the program. To the extent appropriate, please specify the types of stakeholders or other advisory committee meetings that have occurred or are expected to occur under the program.

See Attachment A. I. Background for an executive summary of Family Care including how it was developed and what input was obtained from stakeholders.

II. General Description of the Waiver Program

a. **The State of Wisconsin** requests a waiver under the authority of section 1915(b)(1) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

b. Effective Dates: This waiver is requested for a period of 2 years; effective **July 1, 2001** and ending **June 30, 2003**.

c. The waiver program is called Family Care.

d. State Contact: The State contact person for this waiver is **Charles Jones** and can be reached by telephone at **(608)266-0991**, or fax at **(608) 266-5629**, or e-mail at **jonescm@dhfs.state.wi.us**.

e. Type of Delivery Systems: The State will be entering into the following types of contracts with the MCO or PHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PHP program for mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

1.___ **Risk-Comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient

hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

(a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services

(b)__ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.

2._**X**_ **Other Risk (partially-capitated or PHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PHPs are the contractors in these programs (e.g., a PHP for mental health/substance abuse). References in this preprint to PHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PHP) model, which will be implemented by the State:

(a)__ The contractor is at-risk for inpatient hospital services, OR
(b)_**X**_ The contractor is at-risk for two or fewer of the below services ((i) through (ix)).

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v._**X**_ Skilled nursing facility (NF) services,

vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix._**X** Home Health services; and 1915(c) home and community based services

3.___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the streamlined waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4.___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

f. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

g. **Other Statutory Authority.** The State is also relying upon authority provided in the following section(s) of the Act:

1._**X**_ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2._ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

Please list additional services to be provided under the waiver which

are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

3._**X**_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

h. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1._**X**_ **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2._**X**_ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3._**X**_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

4._**X**_ **Section 1902(a)(30)** - Upper Payment Limits--This Section of the Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the

UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.

Due to the experimental nature of Family Care and the size of some of the Family Care MCOs, Wisconsin would like to waiver section 1902(a)(30) of the Act. This would allow the state to exceed the upper payment limit in certain geographical regions, but demonstrate cost effectiveness on a 'total waiver' basis. Managing the long-term care services included in the Family Care benefit under risk-based contracts has never been undertaken. It has yet to be demonstrated that this model will be a viable one. Particularly in some of the smaller geographical regions of Wisconsin, it may prove difficult to meet the upper payment limits for the Family Care-enrolled populations. This is largely due to fixed overhead costs. However, due to efficiencies in some of the larger regions, the state fully expects to be able to be cost effective on a total waiver basis, demonstrating that total expenditures with the waiver will be below total expenditures without the waiver.

5. **X** **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.

X 1902(a)(4) – requirement for choice of two PHPs or one PHP and a MCO. The state will enter into a sole source contract with counties during the period the state is implementing 1999 WI Act 9 which states: 46.284 (2) Contracts: Before Jan. 1st 2003 the state may not contract with other than a county to operate a CMO in a county unless certain criteria apply.

i. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1.____ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2. X __ Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, please list in the chart

below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PHP, HIO, or other entity) with which the State will contract:

County	Name of Entity*	Type of Entity (e.g., PHP, Staff model HMO)
Fond du Lac	CMO	PHP
La Crosse	CMO	PHP
Portage	CMO	PHP
Richland	CMO	PHP
Kenosha	CMO	PHP

*If the State does not yet know the names of the contracting entities, please generalize the number and type expected. The State should submit the entity names and contracts to the Regional Office as part of the contract prior approval process. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. MCO Requirement for Choice: Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

1.___ This model has a choice of managed care entities.
- (a)__ At least one MCO and PCCM
- (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)
- (c)__ Two or more MCOs
- (d)__ At least one PHP and a combination of the above entities

2.___ This model is an HIO.

3.___ Other: the State requests a waiver of 1932(a)(3). Please list the reasons for the request (Please note: The exception to choice in rural areas, under Section 1932(a)(3) will not apply until final promulgation of the Balanced Budget Act Medicaid Managed Care regulations):

4._**X**_ N/A This model has only PHP entities.

k. **Waiver Population Included:** The waiver program includes the following **targeted** groups of beneficiaries. Check all items that apply: must also meet functional eligibility criteria for Family Care.

(V) means voluntary population

1. **X (V)** Section 1931 Children and Related Poverty Level Populations (TANF/AFDC) ages 18 to 21
2. **X (V)** Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3. ___ Blind/Disabled Children and Related Populations (SSI)

4. **X (V)** Blind/Disabled Adults and Related Populations (SSI)

5. **X (V)** Aged and Related Populations

6. **X (V)** Foster Care Child ages 18 to 21 and who remain in school

7. ___ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8. **X** Other Population(s) Included - If checked, please describe these populations below.
   Individuals, who reside in Family Care counties and who choose to participate in a 1915(c) home and community based waiver.
9. **NA** Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)
   - i. __ Children with special needs due to physical and/ or mental illnesses,
   - ii. __ Older adults,
   - iii. __ Foster care children,
   - iv. __ Homeless individuals,
   - v. __ Individuals with serious and persistent mental illness and/or substance abuse,
   - vi. __ Non-elderly adults who are disabled or chronically ill with developmental or physical disability,
   - vii. __ Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or
   - viii. __ Other (please list):

I. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. ___ have Medicare coverage, except for purposes of Medicaid-only services;

2.___ have medical insurance other than Medicaid;

3.___ are residing in a nursing facility;
4.___ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5. **X** are enrolled in another Medicaid managed care program;

6.___ have an eligibility period that is less than 3 months;

7.___ are in a poverty level eligibility category for pregnant women;

8.___ are American Indian or Alaskan Native;

9.___ participate in a home and community-based waiver;

10. **X** receive services through the State's Title XXI CHIP program;

11. **X** have an eligibility period that is only retroactive;

12. **NA** are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in l. above are listed here (Please explain further in Section F. Special Populations if necessary);
    - i.__ Children with special needs due to physical and/ or mental illnesses,
    - ii.__ Older adults,
    - iii.__ Foster care children,
    - iv.__ Homeless individuals,
    - v.__ Individuals with serious and persistent mental illness and/or substance abuse,
    - vi.__ Non-elderly adults who are disabled or chronically ill with developmental or physical disability,
    - vii.__ Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or
    - viii.__ Other (please list):

13. **X** Have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

    X Individuals who live in a county not included in the Family Care

waiver.

__X__ Individuals who live in a Family Care waiver county who are less than 18 years of age.

__X__ Individuals who do not meet the level of care criteria for the Family Care 1915(c) waiver, i.e., nursing facility or ICF-MR.

__X__ Individuals who do not meet the Family Care target group criteria, i.e., have one of the following: a developmental disability, a physical disability, or infirmities of aging.

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

n. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality, at a minimum, for the first two waiver periods. This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period. [Please refer to SMM 2111 for more information; States may use HCFA's "Independent Assessment: Guidance to States" for further optional guidance].

III. Program Impact

In the following informational sections, please complete the required information to describe your program. The questions should be answered for MCOs and, if applicable, for PHPs.

a. Marketing:

1.___ The State does not permit direct or indirect MCO/PHP marketing (go to item "b. Enrollment/Disenrollment")

2. __X__ The state permits indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general). Please list types of indirect marketing permitted.

CMOs are prohibited from conducting direct or indirect cold calls, either door-to-door or by telephone to market enrollment in the CMO. Indirect marketing activities, such as marketing at health fairs, billboards, bus signs, radio and TV advertising and contacting in person, potential enrollees who request further information about the CMO are not prohibited. All indirect marketing activities must be approved by the state.

As a condition of its contract with the state, the CMO must agree to engage only in marketing/outreach activities that are pre-approved in writing, as follows:

- Prior to the effective date of the contract, the CMO must have a marketing/outreach plan approved in writing by the Department.
- Annually, the CMO must submit an updated marketing/outreach plan to the Department and receive written approval before entering into the next year's contract.
- As part of each marketing/outreach plan or update, and prior to disseminating any materials, the CMO must submit all marketing/outreach materials to the Department for approval, including mailings sent only to members.

The state will review the CMO's marketing/outreach plan and materials. Any problems or errors identified through the review must be corrected by the CMO before entering into the contract.

The standards the state uses when reviewing marketing materials are:

- All enrollment notices and informational and instructional materials relating to enrollment in a CMO must be provided in a manner and form that are easily understood by Medicaid enrollees and potential enrollees.
- Materials must be understandable at a reading level that adequately reflects the potential population to be enrolled.
- Materials must use an easily readable typeface and frequent headings, and should provide short, simple explanations of key concepts.
- Technical or legal language must be avoided whenever possible.
- Information must be available in alternative formats for the visually impaired (through other media such as, large print, Braille, or audio tapes) and for individuals with limited reading proficiency (through video or audio tapes).
- Materials available in foreign languages (see response to 3.a.6.)

3.___ The State permits direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4. **X** The State prohibits or limits MCOs/PHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

The state prohibits the following marketing/outreach practices:

- Any marketing/outreach activities, practices or use of materials that have not received prior written approval from the state.
- Practices that are discriminatory.
- Practices that seek to influence enrollment in conjunction with the sale of any other insurance product.
- Direct and indirect cold calls, either door-to-door or telephone.
- Offer of material or financial gain to potential members as an inducement to enroll.
- Activities and materials that could mislead, confuse or defraud consumers.
- Materials that contain false information.
- Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

The state reviews and approves all member marketing materials. State staff verifies the accuracy of benefit information by checking CMO materials against tools that are contained in Attachment A. III program impact: marketing review tools. The verification process includes reviewing that certain information, such as explanations of appeal rights are accurate. The state also provides guidance for both developing and reviewing marketing materials through its technical assistance guidelines and contract interpretation bulletins. While the state has the authority to do so, it has not required that CMOs use standard formats or terminology in their marketing materials. (The Department has convened a work group of pilot counties and members of the Consumer Awareness Subcommittee of the State LTC Council to consider the use of such standard formats or terminology.)

The state will monitor marketing practices through its procedures for monitoring and evaluating CMO operations, which include collecting and analyzing data from:

- The state-operated Family Care complaint and grievance hotline.
- The state-operated Family Care complaint and grievance system, including the state agency that conducts fair hearings.
- The contracted Family Care independent enrollment broker.
- The contracted Family Care independent advocacy services contractor.

- And other state or contracted sources, e.g., state facility licensing staff, state nursing home ombudsman program, etc.

Staff of appropriate state agencies and of the contracted providers identified above will be trained to identify suspected violations of marketing policies. The Department will ensure that effective communication and reporting systems are in place so that information sources can easily report suspected non-compliance on the part of a CMO.

In addition, periodic audits that include a review of CMO marketing practices will be conducted if warranted. These will include reviews of the CMO's marketing program operations, e.g., standards, training, educational programs, and policies.

5.__ The State permits MCO/PHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6. **X** The State requires MCO/PHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain): Spanish, Hmong, Russian, and Vietnamese as appropriate to the local county population.

The State has chosen these languages because (check any that apply):

i. **X** The languages comprise all prevalent languages in the state ~~MCO/PHP service area~~.

ii.__ The languages comprise all languages in the MCO/PHP service area spoken by approximately ___ percent or more of the population.

iii. **X** Other (please explain):

The CMO must provide materials in formats accessible due to language spoken and various impairments, including but not limited to Braille and large print. Materials shared with potential members and members' families must be understandable in a language and format based on the following:

- Material directed at a specific member (e.g. written communication of intention to deny a service): must be in the language understood by the individual.

- Material directed at potential members or members in general (e.g. member handbook): must be provided in languages prevalent in the CMO service area, and in accessible formats (e.g. Braille, large print).
- All materials: must be in easily understood language and format. Materials must take into account individuals with limited reading proficiency.

- The CMO must provide instructions to members and potential members in the materials on how to obtain information in the appropriate language or accessible format (e.g. sign language) and how to access translation or interpreter services.

7. **MCO Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PHP marketing elements. If an item is not checked, please explain why. The State:

(a) **X** Ensures that all marketing materials are prior approved by the State

CMOs are required to engage only in marketing/outreach activities that are pre-approved in writing, as follows:

- All informational materials that the Enrollment Broker disseminates, that refer to Family Care or the Family Care benefit available through the CMO must be approved by the Department before they are used.
- The CMO is required to have a marketing/outreach plan approved in writing by the Department by the effective date of the PHP contract.
- Annually, the CMO must submit a marketing/outreach plan to the Department and receive written approval before future PHP contracts take effect.
- The CMO must submit to the Department for approval all marketing/outreach materials, including mailings sent only to members, prior to disseminating the materials.

(b) **X** Ensures that MCO marketing materials do not contain false or misleading information

(c) ___ Consults with the Medical Care Advisory Committee (or

subcommittee) in the review of MCO marketing materials

(d) **X** Ensures that the MCO distributes marketing materials to its entire service area

Any marketing and outreach materials that are distributed by the CMO must be made available to the independent enrollment broker, which will make them available to all eligible consumers in the CMO service area who are referred for enrollment counseling .

(e) **X** Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f) **X** Ensures that the MCO does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.

(g) **X** Ensures that MCO does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

The CMO is required to conduct a continuous open enrollment period during which individuals must be enrolled without regard to life situation (e.g., homelessness, need for supervision), health status/condition (e.g., degree of disability, having AIDS), or any other factor(s) provided the individual meets the Family Care HCBS waiver eligibility requirements. Eligibility requirements are that the person:

- Is a resident of a county in which the family care waiver is available
- Is at least 18 years of age
- Has a physical disability, developmental disability, or infirmities of aging
- Is functionally eligible for the HCBS waiver , i.e., has a nursing facility or ICF-MR level of care
- Is financially eligible for the HCBS waiver
- Pays any post eligibility treatment of income obligations required under the HCBS waiver
- Meets other non-financial conditions of eligibility for participation in the HCBS waiver
- Is not currently ineligible for the the HCBS waiver because he or she has divested assets.

Enrollment must occur in the order in which individuals are referred. Practices that are discriminatory and that could reasonably be expected to have the effect of denying or discouraging enrollment are prohibited.

b. Enrollment/Disenrollment: Please describe the State's enrollment process for MCOs/PHPs by checking the applicable items below:

1. **X** **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Family Care Resource Centers have primary responsibility for providing information about the Family Care benefit to potential enrollees. The Resource Center is required to develop and implement an ongoing program of marketing and outreach to the target populations, community agencies and service providers to inform them of the availability of Resource Center services, which includes access to the Family Care benefit delivered by the Care Management Organization (CMO). These functions include implementing operational procedures, data systems, and telephone hotlines, recruiting and training options counseling staff, preparing and distributing outreach materials, and conducting educational forums.

Outreach:
Resource Center outreach responsibilities include implementing a plan for reaching isolated or otherwise hard to reach people who are in the target populations served by the Care Management Organization. This plan may includes training and outreach to police and fire departments, postal employees, pharmacists and others who may have opportunities to recognize people who are in the target populations and in need of information and assistance or long term care services. It also includes outreach and education targeted to children with disabilities and their families.

Pre-Admission Consultation:
Through the pre-admission consultation process, the state assures that all individuals who are seeking admission to a long term care facility (including nursing facilities, assisted living facilities (in Wisconsin referred to as Residential Care Apartment Complexes or RCACs), Community Based Residential Facilities (CBRFs) or Adult

Family Homes (AFHs)) receive options counseling about other potential long term care services available to them. These facilities are statutorily required to refer all prospective residents for pre-admission consultation, which provides them with information about all options, in-home and residential, available to meet their long term care needs, whether provided through Family Care, other available managed care providers (PACE and Wisconsin Partnership Program in some counties), fee-for-service Medicaid state plan services, or services arranged and paid for privately (for persons who have resources that make them financially ineligible for Family Care or other programs).

Availability of Services:
The Resource Center provides information and assistance at hours convenient for the public.

- The Resource Center provides a phone number which is toll free to all callers in the service area.

- The phone number of Resource Center must be answered with the advertised name of the Resource Center.

- The Resource Center service must be available continuously for at least eight hours a day, Monday through Friday (except for official county holidays), including the hours from 11:00 a.m. through 2:00 p.m., at times the Resource Center, in consultation with the Local LTC Council, determines are most convenient for the public. In addition, the information and assistance service must be available an additional 10 hours a month at times the Resource Center, in consultation with the Local LTC Council, determines are most convenient for the public, and must have the capacity to set up an occasional after hours appointment when necessary.

- During Resource Center service hours, a system must be in place to ensure that, except during unusual circumstances, a caller speaks directly to a person, as opposed to an answering machine.

- The Resource Center assures that the community it serves has an easily accessed phone system in place to respond to urgent needs of the target populations. The Resource Center ensures that after hours callers to the Resource Center know what to do in the case of an emergency or urgent need if the Resource Center is closed.

- The Resource Center must meet Department physical accessibility requirements and be able to provide assistance to walk-ins in a private location.

2. **X** **Administration of Enrollment Process**:

(a)__ State staff conduct the enrollment process.

(b) **X** The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of 1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: **to be determined**

ii. Procurement method: **to be determined**

(A)___Competitive

(B)___Sole source

iii. Please list the functions that the contractor will perform:

The enrollment broker is required to

- Provide enrollment counseling to every potential enrollee referred by the Resource Center. (The Resource Center is required to refer every person determined eligible for and interested in enrolling in Family Care.)
- Have the capacity to provide enrollment counseling within 3 business days of the referral from the Resource Center.
- Communicate with each potential enrollee sufficiently to understand the person's situation and provide the person with appropriate information and advice about the service delivery systems and if applicable managed care organizations available.
- Provide timely, accurate, thorough, factual, and unbiased information appropriate to the individual's needs and situation.
- When an individual has made a choice to enroll:
  - Review materials of the specific managed care organization in which the individual has chosen to enroll.
  - Assist the individual to understand, complete and sign the appropriate enrollment form for the specific managed care organization they choose and any other forms required for enrollment, such as release of information forms.
  - Send the enrollment form to the Resource Center within

one business day of the date signed. (The actual date of enrollment in the managed care organization is the "Effective Date of Enrollment" on the Enrollment Form, or the eligibility certification start date, whichever is later.)

(See section 4. (a) below for a more detailed description of the enrollment process.)

(c)__ State allows MCOs/PHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)___ Mandatory for populations in Section A.II.k

(b)_**X**_ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

- Section 1931 Related Poverty Level Populations (TANF/AFDC) age 18 and over only
- Blind/Disabled Adults and Related Populations (SSI)
- Aged and Related Populations
- Foster Care ages 18-21 who remain in school

(c)_**X**_ Other (please describe):

For individuals who are eligible for and want 1915(c) waiver services, enrollment is mandatory in order to access those 1915(c) waiver services. Choices for individuals who choose not to enroll will be limited to Medicaid state plan services, including nursing facility, ICF-MR, community long term care services provided fee-for-service, and other managed care options (e.g., PACE and Wisconsin Partnership in Milwaukee County) where available.

4**. Enrollment:**

(a)_**X**_ The State will make counseling regarding their MCO/PHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

The state will contract with a private entity that is not associated with any county, Resource Center or Care Management Organization. This enrollment broker will offer enrollment counseling to all persons considering enrollment in a Family Care CMO prior to the person making her/his final enrollment decision, and provide it to those who accept the offer.

Accessibility of sites:

The enrollment broker will be required to:

- Provide enrollment counseling in a manner, at a location, and at a time convenient to the potential enrollee.
- Have facilities that meet ADA accessibility standards, but in addition make enrollment counseling available in the person's place of residence or any other setting within the Family Care service area (e.g. hospital) requested by the potential enrollee.
- Ask the potential enrollee to identify any family members or others s/he wants to have present during enrollment counseling, and include those persons when enrollment counseling is provided.
- Provide enrollment counseling outside regular business hours if necessary to meet the needs of the potential enrollee or others s/he wants included.

Telephone access:

The enrollment broker will be required to:

- Offer enrollment counseling via telephone, and if that is the option chosen by the potential enrollee, provide it in that manner, including telephone conferencing with any family members or others the potential enrollee wants to have present during enrollment counseling.
- Meet ADA requirements for telecommunications accessibility.

Counseling process:

The purpose of enrollment counseling is to ensure that potential enrollees have the information necessary to make an informed choice about whether to enroll in Family Care, and if more than one CMO is available, have the information necessary to make an informed choice among CMOs.

The enrollment broker is required to

- Provide enrollment counseling to every potential enrollee referred by the Resource Center. (The Resource Center is required to refer every person determined eligible for and interested in enrolling in Family Care.)
- Have the capacity to provide enrollment counseling within 3 business days of the referral from the Resource Center.
- Communicate with each potential enrollee sufficiently to understand the person's situation and provide the person with appropriate information and advice about the service delivery systems and if applicable managed care organizations available.
- Provide timely, accurate, thorough, factual, and unbiased information appropriate to the individual's needs and situation.
- When an individual has made a choice to enroll, review materials of the specific managed care organization in which the individual has chosen to enroll.
- Assist the individual to understand, complete and sign the appropriate enrollment form for the specific managed care organization they choose and any other forms required for enrollment, such as release of information forms.
- Send the enrollment form to the Resource Center within one business day of the date signed. (The actual date of enrollment in the managed care organization is the "Effective Date of Enrollment" on the Enrollment Form, or the eligibility certification start date, whichever is later.)

The Resource Center ensures that:

- The enrollment request is transferred to the Department's Medicaid fiscal agent in a timely manner for processing on the State's CARES system which authorizes payment to the managed care organization.
- Copies of the following information are transferred to the managed care organization prior to the effective date of enrollment:
- The completed and signed enrollment form
    - The completed Long Term Care Functional Screen
    - Documentation/forms which specify the amount of the member's cost share (if any)
    - Any other forms required by the managed care organization for enrollment, such as a signed release of information

Information provided to potential enrollees:

The enrollment broker:

- Ensures that the individual has received information at the Resource Center about:
  - The full range of fee-for-service long term care service options available to the individual, including home care, community services, case management services, and residential services including nursing home care, and the advantages and disadvantages of each.
  - All available publicly-funded service delivery systems, including Family Care, PACE, Wisconsin Partnership, and Medicaid state plan services, and the advantages and disadvantages of each.
  - Factors to consider when choosing among the available programs and service options, including but not limited to cost, quality, outcomes, estate recovery, compatibility with the person's preferred lifestyle and residential setting, and available resources.
- For persons who choose to enroll in a managed care option, the Enrollment Broker furnishes information about all of the managed care organizations available to the person, including any PACE or Wisconsin Partnership Program site, and any Family Care CMO(s) , and the advantages and disadvantages of each, including a comparison of:
  - The kinds of services available as part of the benefit package, and services that are not covered
  - The provider network
  - Information on accessing services, including:
    - Any restrictions on choice among providers
    - Any special procedures required to obtain services, including any prior authorization requirements
    - The extent to which after-hours and emergency coverage are provided
    - The extent to which enrollees may obtain services from out-of- network providers
    - How transportation is provided
  - The quality of services, including:
    - Available reports on findings from QA/QI studies regarding member feedback (required annually in FC managed care organizations)
    - Available external quality review findings (required annually in FC managed care organizations)

        - Other reports and documents as specified by Federal or State law, if any
      - The rights and responsibilities of enrollees, including any co-payments or cost sharing
      - A description of the complaint, grievance, and fair hearing procedures
    - When an individual chooses to enroll in a specific managed care organization, the Enrollment Broker will provide and explain enrollment notices and informational and instructional materials specific to that managed care organization, including:
      - The member handbook
      - Marketing materials
      - Information about the enrollment process and timing of the person's potential enrollment into the managed care organization

(b) **X** Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe.

The enrollment broker must meet state and federal requirements for accessibility to and accommodation of the special needs of the target populations in the counseling process, including:

- The capacity to communicate, in a timely fashion with people with limited English speaking ability, people who are non-English speaking (e.g., interpreters), people with hearing impairments and persons with physical impairments (e.g., sign language interpreters, TDD, Wisconsin Relay).
- The capacity to provide, in a timely fashion, written materials in alternate formats to accommodate to persons who are non-English speaking and persons with physical impairments (e.g. Braille, large print).
- The capacity to meet face to face with people in the target populations where they are living on an as needed basis.
- Facilities that are physically accessible, and comply with the ADA.
- For people with cognitive disabilities, give special attention to assuring that family members, friends and others who know the individual and can convey the person's needs and preferences are included in the provision of Enrollment

Broker services.

- Have materials for distribution to the target populations and/or the general public that are written in a manner which considers people with limited reading proficiency.

The enrollment broker's counselors will be trained to:

- Understand the needs and risks of Family Care target groups
- Understand the entire local long term care service delivery system, including Family Care
- Present unbiased information about system, program, and service options, including information about local CMO services, provider network and capabilities, and any other special CMO service restrictions or policies.

Counselors will also demonstrate cultural competence and cultural diversity in their performance as demonstrated by:

- The existence of a set of congruent culturally competent behaviors, attitudes, practices and policies that are used within a system and an agency and among professionals working respectfully, effectively and responsibly in providing services in culturally diverse situations/
- Cultural diversity in the workplace, which refers to the degree to which an organization, agency or other group is comprised of people from a variety of differing backgrounds related to behaviors, attitudes, practices, beliefs, values and racial and ethnic identity.

(c) **X** Enrollees will notify the State/enrollment broker of their choice of plan by: (Enrollment counseling will be done primarily in person, unless an alternative procedure is required by the consumer's individual situation. Therefore, in most cases enrollees will notify enrollment broker staff of their choices in person. However, in individual circumstances enrollees may notify the enrollment broker by phone or mail as necessary to meet the consumer's needs.)

i. _**X**_ mail
ii. **_X_** phone
iii. **_X_** in person
iv.___ other (please describe):

(d) **X** [Required for MCOs and PHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open

enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

The open enrollment period is continuous.

(e) **na** Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f) **X** Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

The CMO is required to develop an enrollment plan that must be approved by the Department before the effective date of the contract. This plan must show that the CMO has the capacity to enroll individuals from three sources:

1) People who are currently receiving services from the county fee-for-service long term care programs funded through MA-waiver programs, the state Community Options or Community Aids Programs, or county tax levy.
2) Relocations from nursing facilities and ICFs-MR.
3) New people who are assessed by the Resource Center as meeting the level of care criteria for Family Care (this includes individuals identified through the Pre-Admission Consultation process).

The CMO enrollment plan must show how projected enrollments will be phased in so that within 24 months of the effective date of the first contract the CMO will have enrolled all individuals on waiting lists for Medicaid waiver services. After 24 months of the effective date of the first contract the the DHFS must ensure that there are sufficient resources available to the CMO to be able to offer the Family Care benefit to every eligible and entitled resident of its service area.

The Resource Center is also required to develop and implement a Department-approved plan to ensure access to the Family Care benefit. The Resource Center access plan must be consistent with the enrollment plans of all CMOs in the Resource Center's service area. The Resource Center access plan must demonstrate the capacity to provide all persons in the Resource Center service area potentially eligible for Family Care with initial options counseling

(including providing information about Family Care), and with functional level of care assessment and financial eligibility determination for people who choose to participate in Family Care.

The Resource Center access plan must describe:

- The roles and responsibilities of each participating organization.
- How people will be identified and referred for eligibility determination and re-determination.
- How the functional assessment, financial eligibility and cost share determinations will be made.
- How information will be shared between the participating organizations.
- How affected parties will be notified of the results in a timely fashion.
- How the Resource Center will refer eligible persons who are interested in Family Care to the independent enrollment broker with which the State contracts separately for enrollment counseling services for all potential enrollees.
- How the Resource Center and enrollment broker will process enough enrollments, from the required sources, to allow the CMO to meet its enrollment projections.
- How the independent enrollment broker will maintain availability of enrollment materials.
- How enrollment materials and documents will be transmitted and shared among the enrollment broker, Resource Center and CMO, and how to ensure that the person referred for enrollment has been successfully linked with the CMO.

(g) **na** If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have ____days/month(s) to choose a plan.

ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs?

(h) **na** The State provides guaranteed eligibility of ____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i) **na** The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a) **X** The State allows enrollees to disenroll/transfer between MCOs/PHPs. Please explain the procedures for disenrollment/transfer:

Enrollees can disenroll and return to Medicaid fee-for-service at any time. Medicaid state plan services will be available to any Medicaid-eligible individual who chooses to do so, but in Family Care counties HCBS waiver services will not be available except through Family Care.

Enrollees who disenroll can also choose to transfer to another managed care organization at any time consistent with the new program's enrollment procedures. This includes any Family Care CMO, PACE or Wisconsin Partnership Program site serving the area in which the enrollee resides.

(b)___ The State does not allow enrollees to disenroll from the PHP.

(c) **X** The State monitors and tracks disenrollments and transfers between MCOs/PHPs. Please describe the tracking and analysis:

The reasons for voluntary disenrollments and transfers from a CMO to another CMO or MCO will be reported to the Department quarterly. Disenrollment and transfer reasons and rates will be aggregated and analyzed based on the nature of issues raised by enrollees. This information will be used to develop activities under the CMO's Quality Assurance/Quality Improvement (QA/QI) program to make improvements that address system issues raised in the process. Improvement goals and corrective action plans may be established by the state if necessary.

(d) **na** The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i.___ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.

ii __ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP

ii.___ MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO and PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

(e) **X** The State does not have a lock-in, and enrollees in MCOs/PHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

When a CMO member indicates a desire to disenroll, or to consider disenrolling from the CMO, the CMO will refer the member to the Resource Center. The Resource Center will:

- Contact the individual within two business days to::
  - Discuss the reasons for considering disenrollment.
  - Inform the person of available options to resolve any issues between the CMO member and the CMO, including determining whether the person has considered a complaint or grievance or was in the process of a complaint or grievance.
  - Provide information about other available program and service options if the peron does disenroll
  - Offer to refer the person to the independent enrollment counselor for additional consultation
- If the person chooses to actually disenroll:
  - Jointly determines an effective date of the disenrollment. (The effective date of disenrollment can be the date the member signs the disenrollment form, or a future date. Setting a future date of disenrollment may allow for a smoother transition to a different service delivery system ? whether Medicaid fee for service or a different CMO or MCO. A voluntary disenrollment is effective on the date indicated on the disenrollment form as the effective disenrollment date. Until the effective

date of disenrollment, members are required to continue using the CMO's providers for services in the LTC benefit package. The CMO must continue to provide all needed services in the LTC benefit package until the effective date of disenrollment. To facilitate a member's reinstatement in the fee-for-service system (for members who are Medicaid beneficiaries), the CMO must assist the member in obtaining necessary transitional care through appropriate referrals and by making member records available to new providers.)

- Complete and obtain the person's signature on the CMO Disenrollment Form (which includes the effective date of disenrollment). In the case of a telephone contact, the form will be sent to the person for signature and return.
- Record the reasons for voluntary disenrollment and report them to the Department quarterly. (The Department will collect and analyze information on the reasons for voluntary disenrollments for trend, and take appropriate corrective actions as needed.)

6. **MCO/PHP Disenrollment of Enrollees**: If the State permits MCOs/PHPs to request disenrollment of enrollees, please check items below which apply:

(a) **X** The MCO/PHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, **it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee**. Please describe the reasons for which the MCO/PHP can request reassignment of an enrollee:

A CMO's request to involuntarily disenroll a member must be submitted to the Department. The Department will consider such requests on a case-by-case basis, and allow involuntary disenrollment of a member only if the CMO, for reasons beyond its control, is unable to continue to assure the health and safety of the member or others.

An involuntary disenrollment will be considered an adverse CMO action, and the CMO must comply with contract provisions to provide the member with timely advance notice of

the disenrollment. The member may grieve an involuntary disenrollment using the CMO's or the Department's complaint and grievance resolution process, or may appeal the decision using the state's fair hearing process. (Each of these processes provides for continuation of services pending the outcome of the process.)

(b) **X** The State reviews and approves or denies all MCO/PHP-initiated requests for enrollee transfers or disenrollments.

When the CMO submits a request for disenrollment to the Department, the CMO must also inform the member of the CMOs request for disenrollment and provide information on how the member may grieve that action. If the Department approves a CMO request to involuntarily disenroll a member, the CMO must provide the member with timely advance notice of the disenrollment and refer the member to the Resource Center for options counseling on transitioning out of the CMO and potentially to the independent enrollment counselor if the person wants to enroll another managed care organization. The CMO must continue to serve the member until the effective disenrollment date.

(c) **X** If the reassignment is approved, the enrollee will be notified in a direct and timely manner of the desire of the MCO/PHP to remove the enrollee from its membership.

(For the initial period of the waiver, only one Family Care CMO will be available per service area. Therefore, transition from the CMO may be available only back to the fee-for-service system. When additional CMOs become available, transition to those organizations will be available according to standard enrollment procedures.)

(d) __ The enrollee remains a member of the MCO/PHP until another MCO/PHP is chosen or assigned.

c. Entity Type or Specific Waiver Requirements

1. **X** **Required MCO/PHP Elements:** MCOs/PHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. **X** **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a) **X** The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i. **X** Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii. **X** MCO/PHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii. **X** MCO/PHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv. **X** Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. **X** There are no restrictions that discriminate among classes of providers on ground unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has/will select the MCOs/PHPs that will operate under the waiver in the following manner:

(a) ___ The State has used/will use a competitive procurement process. Please describe.

(b) ___ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c) **X** The State has not used a competitive or open procurement process. Please explain how the State's selection process is

consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

See Attachment A.III.c.3.(c) Sole Source Justification for information on non-competitive contracting.

4) **X** Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.

The state will contract with one or more independent enrollment broker(s) to conduct enrollment choice counseling on behalf of the state. In order to ensure the provision of objective, accurate information to potential enrollees and to reduce the risk of marketing abuses, all potential enrollees' choices of CMO or other MCO provider will be made through an independent enrollment broker. These independent enrollment broker(s) will be separate and independent of any CMO or any other service provider currently operating in the State.

d. SERVICES

1. The Medicaid services MCO/PHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO/PHP contract; which non-covered services are impacted by the MCO/PHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO/PHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as an example only. States should modify the list to include:

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PHP, i.e. not included in the reimbursement paid to the MCO/PHP. However, do not include services impacted by the MCO/PHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO/PHP: Check this column if the service is not the responsibility of the MCO/PHP, but is impacted by it. For example, if the MCO/PHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PHP (see column 5).

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimburse-ment impacted by MCO/PHP (6)
Adaptive Aids – General			X		
Adaptive Aids – Vehicles			X		
Adult Day Care			X		

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimburse-ment impacted by MCO/PHP (6)
Alcohol and Other Drug Abuse Day Treatment (in all settings)	X		X		
AODA Treatment (except those provided by a physician or on an inpatient basis)	X		X		
AODA Treatment (provided by a physician or on an inpatient basis)	X			X	X
Ambulatory Surgical Center Services	X			X	X
Anesthesiology Services	X			X	X
Audiology Services	X			X	X
Blood	X			X	X
Case Management	X		X		
Chiropractic Services	X			X	X
Communication Aids/ Interpreter Services			X		
Community Support Program	X		X		
Counseling/ Therapeutic Resources			X		
Crisis Intervention	X			X	X
Daily living skills training			X		
Day Services			X		
Dental Services	X			X	X
Diagnostic Testing Services (Lab & X-ray)	X			X	X
Dialysis Services	X			X	X
Drugs	X			X	X

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimburse-ment impacted by MCO/PHP (6)
Durable Medical Equipment (excluding hearing aids and prosthetics)	X		X		
Disposable Medical Supplies	X		X		
Early and Periodic Screening, Diagnosis and Treatment	X			X	X
Eyeglasses	X			X	X
Federal Qualified Health Clinic (FQHC) Services	X			X	X
Family Planning Services	X			X	X
Foster Home for persons age 18-21 who remain in school	X		X		
Foster Home for persons under age 18	X			X	X
Hearing Aids	X			X	X
Home Health Services	X		X		
Home Modifications			X		
Hospice	X			X	X
Hospital Services	X			X	X
In-Home Autism Treatment for persons age 18 and over	X		X		
In-Home Autism Treatment for persons under age 18	X			X	X
In Home Intensive Psychotherapy	X		X		
Independent Nurse Practitioner Services	X			X	X
Lab and X-Ray	X			X	X

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimburse-ment impacted by MCO/PHP (6)
Meals-Home Delivered			X		
Mental Health Counseling/Therapy (except those provided by a physician or on an inpatient basis)	X		X		
Mental Health Counseling/Therapy (provided by a physician or on an inpatient basis)	X			X	X
Mental Health Day Treatment	X		X		
Mental Health Inpatient	X			X	X
Nurse-midwife Services	X			X	X
Nursing Home Stays (including Nursing Home, Institution for Mental Disease (IMD) and ICF-MR Facility)	X		X		
Occupational Therapy	X		X		
Outpatient Hospital Services (other than those specifically included)	X			X	X
Personal Care	X		X		
Personal Emergency Response System Services			X		
Physical Therapy	X		X		
Physician/Clinic Services	X			X	X
Podiatry Services	X			X	X
Prenatal Care Coordination Services	X			X	X
Prevocational Services	X		X		

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimburse-ment impacted by MCO/PHP (6)
Private Duty Nursing Services	X		X		
Prosthetics	X			X	X
Residential Services – RCAC, CBRF, Adult Family Home			X		
Respiratory Therapy by Independent Nurse or therapist employed by Home Health Agency	X		X		
Respite Care			X		
RHC	X			X	X
School-based Services	X			X	X
Skilled Nursing	X		X		
Specialized Medical Supplies			X		
Speech and Language Pathology Services (except in inpatient hospital settings)	X		X		
Speech and Language Pathology Services (in inpatient hospital settings)	X			X	X
Supported Employment			X		
Supportive Home Care			X		
Transportation – Air/Ground Ambulance	X			X	X
Transportation – Medical (including specialized medical vehicle)	X		X		
Transportation – Non-medical			X		
Vision Care Services	X			X	X

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. For PHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

For MCOs, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Inpatient and outpatient services that may be needed to evaluate or stabilize an emergency condition are not a covered benefit in Family Care CMOs, which will be operating under a PHP.

(a) **na** The State has a more stringent definition of emergency medical condition for MCOs or PHPs than the definition above. Please describe.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b) **X** The State ensures enrollee access to emergency services by requiring the MCO/PHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

Inpatient and outpatient emergency services are not covered in Family Care. However, Care Management Organizations will arrange for emergency services not covered in the LTC benefit package from other sources and instruct all members on where and how to obtain them, including how transportation is provided. The mechanism the CMO uses to coordinate these services for its members is the care management team.

(c) **na** The State ensures enrollee access to emergency services by including in the contract requirements for MCOs/PHPs to cover the following. Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.

Acute care emergency services are carved out of the Family Care benefit package. CMO Member Handbooks explain that members should access emergency medical care as they would in any case, such as by calling 911.

i.____ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii.___ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.___ Both the screening/evaluation and stabilization services when a clinical emergency is determined,

iv.___ Continued emergency services until the enrollee can be safely discharged or transferred,

v.____ Post-stabilization services which are pre-authorized by the MCO/PHP, or were not pre-authorized, but the MCO/PHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PHP contacts the emergency room and takes responsibility for the enrollee.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program. Family Planning services are carved out.

(a) **na** Enrollees are informed that family planning services will not be

restricted under the waiver.

(b) **na** Non-network family planning services are reimbursed in the following manner:

i. ____ The MCO/PHP will be required to reimburse non-network family planning services

ii. ____ The MCO/PHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii. ____ The State will pay for all family planning services, whether provided by network or non-network providers

iv. ____ The State pays for non-network services and capitated rates were set accordingly.

v. ____ Other (please explain):

(c) **X** Family planning services are not included under the waiver.

4. **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

For services in the Family Care benefit package, the CMO coordinates services for its enrollees through the care management team. Each CMO decides whether or not to allow its enrollees to self-refer for specific services (see Attachment B Access and Capacity for a thorough description of this process). The CMO's policies and procedures on self-referral must be specified in the member handbook.

5. **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PHP to track, coordinate, and monitor services to which an enrollee can self-refer:

Tracking, coordinating, and monitoring services to which an enrollee can self-refer varies by CMO based on its referral policies. However, each CMO must record all referral requests for services to an

enrollee, along with the disposition of the referral. Aggregate data on referrals can then be compiled for use in quality assessment and monitoring and must be made available upon request to the Department.

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

FQHCs are not in Family Care benefit package.

(a) **na** The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO/PHP to the enrollee during the enrollment period.

(b) **na** The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available._____

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PHP with a participating FQHC:

(c) **X** The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State will coordinate and monitor EPSDT services under the waiver program as follows (If the State has a PHP, please note any relevant EPSDT/immunization data):

EPSDT services are carved out.

(a) **na** The State requires MCOs/PHPs to report EPSDT data, including behavioral health data. Please describe the type and

frequency of data required by the State.

(b) **na** EPSDT screens are covered under this waiver. Please list the State's EPSDT screening rates, including behavioral components, for the past two years, for the Medicaid population as a whole. (Please note*: HCFA requests that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline may be the data reported in the HCFA 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates will be monitored in future renewals.) Please describe any activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c) **na** Immunizations are included in this waiver. Please list the State's immunization rates for the past two years for the Medicaid population as a whole. *See note in (b) above. What activities will the State initiate to improve immunization rates for enrollees within the waiver?

(d) **na** Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e) **na** Mechanisms are in place to coordinate school services with those provided by the MCO/PHP. Please describe.

Section B. Access and Capacity

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Access Standards

a. Availability Standards: The State has established maximum distance and travel time requirements, given clients normal means of transportation, for MCO/PHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

Acute and primary services are carved out of Family Care.

See Attachment B Access and Capacity for a description of standards established for Family Care CMOs and how the state will monitor compliance with standards and CMO performance related to access and capacity.

1. **na** PCPs (please describe your standard):

2. **na** Specialists (please describe your standard):

3. **na** Ancillary providers (please describe your standard):

4. **na** Pharmacies (please describe your standard):

5. **na** Hospitals (please describe your standard):

6. **na** Mental Health (please describe your standard):

7. **na** Substance Abuse Treatment Providers (please describe your standard):

8. **na** Dental (please describe your standard):

9. ___ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and

what incentives/sanctions/enforcement the State makes with each of the standards described above.

11. Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

12. Please explain how the MCOs/PHPs will be required to enable enrollees to access providers.

b. Appointment Scheduling (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

Acute and primary services are carved out of Family Care.

See Attachment B Access and Capacity for a description of standards established for Family Care CMOs and how the state will monitor compliance with standards and CMO performance related to access and capacity.

1. **na** PCPs (please describe your standard):

2. **na** Specialists (please describe your standard):

3. **na** Ancillary providers (please describe your standard):

4. **na** Pharmacies (please describe your standard):

5. **na** NA Hospitals (please describe your standard):

6. **na** Mental Health (please describe your standard):

7. **na** Substance Abuse Treatment Providers (please describe your standard):

8. **na** Dental (please describe your standard):

9. ___ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

11. Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

Acute and primary services are carved out of Family Care.

See Attachment B Access and Capacity for a description of standards established for Family Care CMOs and how the state will monitor compliance with standards and CMO performance related to access and capacity.

1. **na** PCPs (please describe your standard):

2. **na** Specialists (please describe your standard):

3. **na** Ancillary providers (please describe your standard):

4. **na** Pharmacies (please describe your standard):

5. **na** Hospitals (please describe your standard):

6. **na** Mental Health (please describe your standard):

7. **na** Substance Abuse Treatment Providers (please describe your standard):

8. **na** Dental (please describe your standard):

9. ___ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above.

11. Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.

II. Access and Availability Monitoring:

Enrollee access to care will be monitored as part of each MCO/PHP's Internal

Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA). Check below any of the following (1-11) that the State will **also** utilize to monitor access and answer question 12:

a. **X** Measurement of access to services during and after a MCO/PHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

b. **X** Determination of enrollee knowledge on the use of managed care programs

c. **X** Ensures that services are provided in a culturally competent manner to all enrollees.

d. **X** Review of access to emergency or family planning services without prior authorization. (These services are carved out of Family Care.)

e. **X** Review of denials of referral requests

f. **X** Review of the number and/or frequency of visits to emergency rooms, ~~non-authorized visits to specialists, etc., for medical care~~. (Specialty medical services are carved out of Family Care.)

g. **X** Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

h. **X** Measurement of enrollee requests for disenrollment from a MCO/PHP due to access issues

i. **X** Tracking of complaints/grievances concerning access issues

j. ___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

k. **X** Monitoring access to ~~prescriptions on the State Plan Formulary~~, Durable Medical Equipment, and therapies. (Pharmaceuticals are carved out of Family Care.)

l. **X** During monitoring, the State will look for the following indications of access problems.

1. **na** Long waiting periods to obtain services from a PCP. (PCP services

are carved out of Family Care.)

2. **na** Denial of referral requests when enrollees believe referrals to specialists are medically necessary. (Specialty medical services are carved out of Family Care.)
3. X Confusion about how to obtain services not covered under the waiver.
4. **na** Lack of access to services after PCP's regular office hours. (PCP services are carved out of Family Care.)
5. **na** Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care. (These services are carved out of Family Care.)
6. **na** Lack of access to emergency or family planning services. (These services are carved out of Family Care.)
7. **na** Frequent recipient requests to change a specific PCP. (PCP services are carved out of Family Care.)
8. Other indications (please describe):

m. **X** Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n. **X** Monitoring the provider network showing that there will be providers within the distance/travel times standards.

o. **X** Other (please explain):

Services provided by the care management interdisciplinary team will be monitored for access and availability.

III. Capacity Standards

a. MCO/PHP Capacity Standards

1. **X** The State has set enrollment limits for the MCO/PHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

   The State has not set enrollment limits for Family Care PHPs.

2. **X** The State monitors to ensure that there are adequate open panels within the MCO/PHP. Please describe how often and how the monitoring takes place.

   The adequacy of Family Care CMO provider panels is examined by the state prior to initial certification as a CMO, and as part of an

annual recertification process thereafter. (Acute and primary care are carved out of Family Care.)

3. **X** [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

See Attachment B. Access and Capacity

4. **X** [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before and after the waiver. Please provide a definition of your geographic area, i.e. by county, region or capitated rate area. Please complete only for the providers included in your waiver program.

The geographic areas applicable to Family Care in Wisconsin are the following:

County	Name of Entity	Type of Entity (e.g., PHP, Staff model HMO)
Fond du Lac	CMO	PHP
La Crosse	CMO	PHP
Portage	CMO	PHP
Richland	CMO	PHP
Kenosha	CMO	PHP

For **risk-comprehensive programs**, please modify to reflect your State's program and complete the following chart (Note: HCFA is requesting baseline information that will be used by the Regions for contract approval and for future waiver renewals.):

Family Care is not a risk comprehensive program

Providers	# Before the Waiver	Projected # After the Waiver
FQHCs		
Hospitals		
Pharmacies		
Primary Care Providers (Please specify) - Family Practice - Internal Medicine		

Providers	# Before the Waiver	Projected # After the Waiver
- OB/GYNs - Pediatricians - Physician Extenders		
Other (please specify) add Family Care services		

*Please **note any limitations** to the data in the chart above here:
For other risk programs, please modify for your State's program and complete the following chart (Note: HCFA is requesting baseline information that will be used by the Regions for contract approval and for future waiver renewals):

See Attachment B. Access and Capacity for response.

Providers	# Before the Waiver	Projected # After the Waiver
Developmental Disabilities Providers (please specify)		
Hospitals		
Mental Health Providers (please specify)		
Pharmacies		
Substance Abuse Treatment & Rehab Providers (please specify)		
Transportation Providers (please specify)		
Vision Providers		
Other (please specify)		

*Please note any limitations to the data in the chart above here:

b. X PCP Capacity Standards

Note: Physicians are not included in the Family Care benefit. Therefore, the capacity standards address case managers rather than primary care physicians.

The care management team shall have sufficient contact and interaction with members to develop and maintain a relationship, be responsive to changing member needs and preferences, and monitor the appropriateness and quality of services. These contacts shall be recorded in the member record.

1. The State has set capacity standards for PCPs within the MCOs/PHP expressed in the following terms (In the case of a PHP, a PCP may be defined as a case manager or gatekeeper):

   i.___ PCP to enrollee ratio
   ii.___ Maximum PCP capacity
   iii.___ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans?

2.___ The State ensures adequate geographic distribution of PCPs within MCO/PHPs. Please explain.

3.___ The State designates the type of providers that can serve as PCPs. Please list these provider types.

c. Specialist Capacity Standards

Except for non-physician mental health and substance abuse services, specialists' services are carved out of Family Care. See Attachment B. Access and Capacity for response.

1._**na**_ The State has set capacity standards for specialty services. Please explain.

2._**na**_ The State monitors access to specialty services. Please explain how often and how monitoring is done.

3._**na**_ The State requires particular specialist types to be included in the MCO/PHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. speciality to enrollee ratio. If specialists types are not involved in the MCO/PHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

Specialist Provider Type	Adult	Pediatric	Standards
Addictionologist and/or Certified Addiction Counselors			
Allergist/Immunologist			
Cardiologist			
Chiropractors			
Dentist			
Dermatologist			

Specialist Provider Type	Adult	Pediatric	Standards
Emergency Medicine specialist			
Endocrinologist			
Gastroenterologist			
Hematologist			
Infectious/Parasitic Disease Specialist			
Neurologist			
Obstetrician/Gynecologist			
Oncologist			
Ophthalmologist			
Orthopedic Specialist			
Otolaryngologist			
Pediatrician			
Psychiatrist			
Pulmonologist			
Radiologist			
Surgeon (General)			
Surgeon (Specialty)			
Other mental health providers (please specify)			
Other dental providers(please specify)			
Other (please specify)			

IV. Capacity Monitoring

Please indicate which of the following activities the State employs:

a.___ Periodic comparison of the number and types of Medicaid providers before and after the waiver.

b.___ Measurement of referral rates to specialists.

c.___ Provider-to-enrollee ratios

d.__**X**__ Periodic MCO/PHP reports on provider network

e.__**X**__ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f.__**X**__ Tracking of complaints/grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i.___ Tracking of termination rates of PCPs

j.___ Review of reasons for PCP termination

k. **X** Consumer Experience Survey, including persons with special needs,

l. **X** Other (Please explain): State certification and annual recertification of the adequacy of the CMO provider network.

V. Continuity and Coordination of Care Standards

Check any of the following that the State requires of the MCO/PHP:

a. **na** Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs

b. **X** Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care. See Attachment B. Access and Capacity.

c. **X** Health education/promotion. **Please explain**. See Attachment B. Access and Capacity.

d. **X** Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the MCO/PHP, taking into account professional standards

e. **X** There is appropriate and confidential exchange of information among providers.

f. **X** Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g. **X** Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

h. **X** Case management (please define case management program requirements). See Attachment B. Access and Capacity.

VI. Continuity and Coordination of Care Monitoring

a. How often and through what means does the State monitor the coordination

standards checked above? Semiannual site visits during the first contract year, and annual site visits thereafter.

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the MCO/PHP to coordinate health care services excluded from the capitated waiver with:

See Attachment B. Access and Capacity for a more complete response.

1. **X** Mental Health Providers (please describe how the State ensures coordination exists): The CMO's care management team assures coordination with psychiatrists and other mental health providers as needed.
2. **X** Substance Abuse Providers (please describe how the State ensures coordination exists): The CMO's care management team assures coordination with psychiatrists, physicians and other substance abuse providers as needed.

3. **X** Local Health Departments (please describe how the State ensures coordination exists): The CMO's care management team assures coordination with local health department services as needed.

4. **X** Dental Providers (please describe how the State ensures coordination exists): The CMO's care management team assures coordination with dental providers as needed.

5. **X** Transportation Providers (please describe how the State ensures coordination exists): Transportation (except for ambulance) is included in the benefit package. The CMO's care management team assures coordination with all transportation providers. (Common carrier trasnoirtation services were inadvertently excluded from the original benefot package, but the Department intends to add them in the future.)

6. **na** HCBS (1915c) Service (please describe how the State ensures coordination exists): This is a (b) / (c) combination waiver. The CMO's care management team assures coordination of waiver services with all other services available to the participant.

7. **X** Developmental Disabilities (please describe how the State ensures coordination exists): The CMO's care management team assures coordination with developmental disabilities services not included in the program's networks as needed.

8. **X** Title V Providers (please describe how the State ensures

coordination exists): The CMO's care management team assures coordination with maternal and child healh providers as needed.

9. **X** Women, Infants and Children (WIC) program: The CMO's care management team assures coordination with the WIC program as needed.

10. **X** Indian Health Services providers: The CMO's care management team assures coordination with Indian Health Services providers as needed.

11. **X** FQHCs and RHCs not included in the program's networks: The CMO's care management team assures coordination with FQHCs and RHCs not included in the program's networks as needed.

12. **X** Other (please describe): The CMO's care management team assures coordination with hospitals, physicians and physicians' clinics as needed.

Section C. Quality of Care and Services

General: A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize MCOs or PHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver description will document how the State has planned to meet these requirements.

See Attachment C. I. Elements of State Quality Strategy

I. Elements of State Quality Strategies:

This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations. Please check any of the items below that the State requires. Note: Elements a, b, f, and g are required elements. In addition, elements c and e are required for States with MCOs and element d is required for States with PHPs. The State:

a. **X** Includes in its contracts with MCOs/PHPs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently required of MCOs/PHPs in their contracts as an attachment to this section (Attachment C.I.a).

See Attachment C.I.a. QA/QI Standards and Guidelines

b. **X** Monitors, on a continuous basis, MCOs/PHPs adherence to the State standards, through the following mechanisms (check all that apply):

1. **X** Review and approve each MCOs/PHPs written QAP. Such review must take place prior to the State's execution of the contract with the MCO/PHP.

2. **X** Review each MCOs/PHPs written QAP on a periodic schedule after the execution of the contract. Please specific frequency:

During the CMO's pre-certification review and annually before contract renewal.

3. **X** On-site (MCO/PHP administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's Quality standards. Such monitoring will take place (specify frequency) **annually** for each MCO/PHP or attach the

scope of work from the EQRO contract as an attachment to this section.

4. **X** Conducts monitoring activities using (check all that apply):

   (a) **X** State Medicaid agency personnel
   (b) ___ Other State government personnel (please specify):
   (c) **X** A non-State agency contractor (please specify): The Management Group, Metastar, or a competitively selected vendor.

5. ____ Other (please specify):

c. **X** Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each MCO contract with the State. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. Please specify the name of the entity: Unknown

2. The entity type is: Unknown
   (a) ___ A Peer Review Organization (PRO).
   (b) ___ A private accreditation organization approved by HCFA.
   (c) ___ A PRO-like entity approved by HCFA.

3. Please describe the scope of work for the External Quality Review Organization (EQRO): Unknown

d. **X** Has established a system of periodic medical audits of the quality of, and access to, health care for each PHP on at least an annual basis. These audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PHPs. These periodic medical audits will be conducted by:

1. The entity type is:
   (a) **X** State Medicaid agency personnel
   (b) ___ Other State government personnel (please describe):
   (c) **X** A non-State agency contractor to the State (please describe):
   (d) ___ Other (please describe):

2. Please attach the scope of work for the periodic medical audits. See Attachment C. I. for a description of the state's monitoring and oversight strategy.

e. **na** Has established intermediate sanctions that it may impose if the State makes a determination that an MCO violates one of the provisions below. (Note: does not apply to PHPs).

f. **X** Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g. **X** Has standards in the State QAPI, at least as stringent as those required in federal regulation, for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

h. **na** Plans to develop and implement the use of QISMC in its quality oversight of MCOs/PHPs? (QISMC is a HCFA initiative to strengthen MCOs/PHPs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is strictly a voluntary initiative for states) Please explain which domains will the State be implementing (check all that apply).

1.___ Domain 1: Date of Implementation _____

2.___ Domain 2: Date of Implementation _____

3.___ Domain 3: Date of Implementation _____

4.___ Domain 4: Date of Implementation _____

i.___ Other (please describe)**:**

II. Coverage and Authorization of Services

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs meet coverage and authorization requirements. Contracts with MCOs/PHPs:

a. **X** Identify, define and specify the amount, duration and scope of each service offered, differentiating those services which may be only available to special needs populations, as appropriate.

b. **X** Specify what constitutes "medically necessary services" consistent with the

State's Medicaid State Plan program. Please list that definition:
The definitions of Family Care benefit services as defined by the PHP contract are:

Services Necessary to Achieve Outcomes—services necessary to achieve outcomes identified in the member's Individual Service Plan include both "necessary long term care services" and "medically necessary services." The CMO can offer reasonable alternative services that meet a member's needs and desired outcomes at less expense. Reasonable alternatives are those which: (1) have been effective for persons with similar needs; and (2) would not have significant negative impact on desired outcomes.

Necessary Long Term Care Services and Supports—include any service or support that is provided to assist a member to complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:

- Is consistent with the member's comprehensive assessment and individual service plan;
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Is appropriate with regard to Department's and CMO's generally accepted standards of long term care and support;
- Is not duplicative with respect to other services being provided to the member;
- With respect to prior authorization of a service and other prospective coverage determinations made by the CMO, is cost-effective compared to an alternative necessary long term care service which is reasonably accessible to the member; and
- Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

Medically Necessary Services—are Medicaid services (as defined under s. 49.46 Wis. Stats. and ch. Wis Admin. Code 107) that are required to prevent, identify or treat a member's illness, injury or disability, and that meet the following standards:

- Is consistent with the member's symptoms or with prevention, diagnoses or treatment of the member's illness, injury or disability;
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Is appropriate with regard to generally accepted standards of medical

practice;

- Is not medically contraindicated with regard to the member's diagnoses, symptom, or other medically necessary services being provided to the member;
- Is of proven medical value or usefulness and, consistent with s. HSS 107.035, is not experimental in nature;
- Is not duplicative with respect to other services being provided to the member;
- Is not solely for the convenience of the member, the member's family or a provider;
- With respect to prior authorization of a service and other prospective coverage determinations made by the Department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and
- Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

c. **X** Provide that the MCO/PHP furnishes the services in accordance with the definition of "medically necessary services".

d. **X** Ensure implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1. **X** Specific time frames for responding to requests,

2. **X** Requirements regarding necessary information for authorization decisions,

3. **X** Provisions for consultation with the requesting provider when appropriate,

4. **X** Providing for expedited response for urgently needed services

5. **X** Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6. **X** Criteria for decision on coverage and medical necessity are updated regularly.

7. **X** Mechanisms to ensure consistent application of review criteria and compatible decisions.

8. **X** A process for clinical peer reviews (i.e., LTC professional) of decisions to deny authorization of services on the grounds of medical appropriateness.

9. **X** Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or discontinued.) Notices include (check all that apply):

(a) **X** Criteria used in denying or limiting authorization

(b) **X** Information on how to request reconsideration of the decision.

(c) ___ Other (please describe):

10. **X** Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11. **X** Mechanisms to detect both under utilization and over utilization of services.

12. ___ Other (please describe):

e. ___ Other (please describe):

III. Selection and Retention of Providers

Please check any processes or procedures listed below that the State uses to ensure that each MCO/PHP implements a documented selection and retention process for its providers. The State requires MCOs/PHPs to (please check all that apply):

a. **X** Develop and implement a documented process for selection and retention of providers.

b. **X** Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source

verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c. **X** Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1. **X** Initial credentialing

2. **X** Performance indicators, including those obtained through the following (check all that apply):

(a) **X** The quality assessment and performance improvement program

(b) **X** The utilization management system

(c) **X** The grievance system

(d) **X** Enrollee satisfaction surveys

(e) ___ Other MCO/PHP activities as specified by the State.

d. **X** Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e. **X** Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State: Every two years.

f. **X** Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g. **X** Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

The CMO must notify the Depsartment when it terminates a contract with a CMO network provider because of quality problems.

h. ___ Other (please describe):

IV. Delegation

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs/PHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. Where any functions are delegated by MCOs/PHPs, the State Medicaid Agency:

a. **X** Reviews and approves (check all that apply):

1. **X** All subcontracts with individual providers or groups

2. **X** All model subcontracts and addendums

3. ____ All subcontracted reimbursement rates

4. ____ Other (please describe):

b. **X** Requires agreements to be in writing and to specify any delegated responsibilities.

c. **X** Requires agreements to specify reporting requirements.

d. **X** Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e. **X** Monitors to ensure that MCOs/PHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f. **X** Ensures that MCOs/PHPs monitor the performance of the entity on an ongoing basis.

g. **X** Monitors to ensures that MCOs/PHPs formally review the entity's performance at least annually.

h. **X** Ensures that MCOs/PHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i. ____ Other (please explain):

V. Practice Guidelines

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs develop (or adopt) and disseminate practice guidelines (please check all that apply). Guidelines:

a. **X** Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b. **X** Consider the needs of the MCOs/PHPs enrollees.

c. **X** Are developed in consultation with contracting health professionals.

d. **X** Are reviewed and updated periodically.

e. **X** Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f. **X** Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g. **X** Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

h.___ Other (please explain):

VI. Health Information Systems

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. The State requires that MCOs/PHPs systems:

a. **X** Provide information on
1. **X** Utilization,
2. **X** Grievances,
3. **X** Disenrollment.

b. **X** Collect data on enrollee and provider characteristics as specified by the State.

c. **X** Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe).

The Human Services Reporting System (HSRS) will be used to collect data on services furnished to CMO enrollees. These data are automated to allow for tracking of participants. CMOs will also have their own client assessments and data collection and management systems. Selected data from these will be transferred to state data collection systems.

The MCO/PHP is capable of (please check all that apply):

1. **X** Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2. **X** Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors

3. **X** Verifying the accuracy and timeliness of data
4. **X** Screening data for completeness, logic and consistency

5. **X** Collecting service information in standardized formats to the extent feasible and appropriate

6. ____ Other (please describe):

d. **X** Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

See Attachment C.VI.d. Description of Performance Measure Data Set

1. **X** Health services (please specify frequency and provide a description of the data and/or content of the reports) Annually

2. **X** Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports) Annually

3. **X** Encounter Data (please specify frequency and provide a description of the data and/or content of the reports) Monthly, See Attachment C.VI.d.3. HSRS Fields

4. ____ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e. **X** Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f. **X** Ensure that information and data received from providers are accurate, timely and complete.

g. **X** Allow the State agency to monitor the performance of MCOs/PHPs using

systematic, ongoing collection and analysis of valid and reliable data.

h. **X** Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.____ Other (please describe):

VII. Quality Assessment and Performance Improvement (QAPI)

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain an adequate QAPI. The State requires that MCOs/PHPs (check all that apply):

a. **X** Have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPI. The State has standards which include (check all that apply):

1. **X** A policy making body which oversees the QAPI

2. **X** A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3. **X** Active participation by providers and consumers

4. **X** Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.____ Other (please describe):

b. **X** Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the applicable agency. Please list or attach the standard measures currently required.

See Attachment C.I. for a list of the standard performance measures that are required to be reported by the CMO. See Attachment C.VI.d. for description of data for performance measures.

c. **X** Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the standardized quality measures established by the State Medicaid agency.

Wisconsin requires by contract that the CMO achieves required minimum

levels of performance that may be established by the state and report such performance to the Department. The CMO must meet any goals for performance improvement on specific measures that may be established by the Department. During the first year of the waiver, minimum performance levels will not be established on the performance measures that are required by the contract. The Department plans to collect baseline data during the first contract period and establish performance levels based on these data during subsequent contract periods. See Attachment C.I. for a complete listing of CMO performance measures.

d. **X** Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

Each CMO, by the end of 2000 must initiate one Performance Improvement Project. The CMO's chosen project must be selected from one of three focus areas: 1) self-determination and choice, 2) community integration, or 3) health and safety, **and** on at least one of the Family Care member outcomes within the chosen focus area. Within the chosen focus area and outcome, the CMO must:

- Develop specific measurable outcome indicators that will assist in measuring progress towards improving the broad outcome.
- Demonstrate improvement in the project by the end of 2001.

Each CMO must also complete one additional Performance Improvement Project by the end of the second contract year that is not an extension of the first project.

See Attachment C. VII.d. Performance Improvement Projects of the CMO contract for a description of the types of issues that are included in the focus areas defined by the State.

e. **X** Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f. **X** Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g. **X** Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h. **X** Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

i. **X** Select and prioritize topics for projects to achieve the greatest practical benefit for enrollees.

j. **X** Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k. **X** Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l. **X** Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m. **X** Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n. **X** Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

o. **X** Use a sampling methodology that ensures that results are accurate and reflective of the MCOs/PHPs enrolled Medicaid population.

p. **X** Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q. **X** Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r. **X** Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s. **X** Administer their QAPI through clear and appropriate administrative

arrangements.

t. **X** Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

u. ___ Other (please describe):

Section D. Cost Effectiveness

In order to demonstrate cost effectiveness, a waiver request must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver. With respect to waivers involving capitated reimbursement, a State's computation of its UPL (as required by 42 CFR 447.361) may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver as well. **The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.**

HCFA offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the streamlined waiver preprint format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the streamlined preprint is optional.

- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).

- States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial preprint. In addition, States will also not be held accountable for benefit package, payment rate, or other programmatic changes made to the waiver program.

- Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's HCFA accountant in the Regional Office.

- A set of sample preprint Appendices has been included with this preprint using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's UPL and rate development techniques, using the State's capitated rate cells (most states use eligibility category, age, and gender-adjusted cells)**. If a waiver program does not cover all categories of service, the State should modify the spreadsheet to include only covered services. Please submit the electronic spreadsheets used to create the Appendices to HCFA (HCFA currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.

- The costs and enrollment numbers for voluntary populations (i.e., populations which can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, HCFA believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the rate setting or with waiver calculations. HCFA may require the State to adjust its upper payment limits for the voluntary population to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:
In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or PHP) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a FFS basis. Documentation for the without waiver costs must be calculated on a per member per month basis.

- In order to determine cost-effectiveness, States must first estimate the number of member months for the target population which will participate in the waiver program (Appendix D.II, Steps 1-4). The member months estimation should be based on the actual State eligibility data in the base year.

- The base year and the source of the without waiver data need to be identified. The sources for this data and any adjustments to this data must be listed (Appendix D.III, Steps 5-9). Without Waiver Costs should be created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. HCFA recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates.

- Statistically valid (as defined by the State's actuary) without waiver cost and eligibility data for the population to be covered must be established. Base years should be specific to the eligibility group and locality covered by the contract and, to the extent possible, the costs included in the capitation rates. The exception to this would be where the size of the group is not sufficiently large to represent a statistically valid sample. These base year costs need to be broken down into each of the main service categories covered under the contract--inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs (Appendix D.IV, Steps 10-13).

- Once the base year costs are established, States need to make adjustments to that data in order to update it to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into

the base year costs, the end result is a projected UPL for the year under contract (Appendix D.IV, Steps 14-16). The State then needs to consider the effect of costs which are outside the capitation rate (and therefore outside the UPL), but are affected by the capitated contractor. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the capitated contractor can affect the costs of these wraparound services, they must be included in the without waiver cost development (Appendix D.IV, Steps 17-18).

- States must estimate the PMPM costs under the waiver, including services controlled by the waiver but not in the capitated rate, plus the agency's average per capita administrative costs related to these services (Appendix D.V, Steps 19-29).

- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, Steps 30-35).

- States must clearly demonstrate that, when compared, payments to the contractor do not exceed the UPL (Appendix D.VIII, Steps 36-37), and costs under the waiver do not exceed costs without the waiver (Appendix D.VIII, Steps 38-40).

Assurance (Please initial or check)

___X___ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer:__Peggy Bartels_____

Telephone Number:_____(608) 266-8922_____

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract

The response to this question should be the same as in **A.II.e**.

a.____Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs)
b.__**X**__Other risk (partially-capitated--PHP)
c.____Non-risk. Please use Section C of the PCCM initial application.
d.____Other (please explain):

II. Member Months:

Appendix D.II.
Purpose: To provide data on projected enrollment during the waiver

period. Projected enrollment data is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which will be used in setting capitation rates under the waiver. The number and distribution of rate cells will vary by State. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 2.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 2.

a. Population in base year data

1. **X** Base year data is from the **same** population as to be included in the waiver.

- Eligibility data were taken from Wisconsin's Medicaid Management Information System (MMIS) and Human Service Reporting System (HSRS).
- Medicaid eligibility per se was taken from the MMIS, while the waiver under which a person was served in the base year was taken from the HSRS.
- The base year population includes all waiver eligibles in calendar year 1998, who were served in the county(-ies) for which this waiver application is being submitted.
- This is the population that would be mandatorily enrolled in Family Care in state fiscal years 2002 - 2003.
- Using these historical data, distributions were established for each participating CMO county, across Wisconsin's four current federal waiver programs.
- These distributions were then applied to state fiscal year 2002 and 2003 projections of total CMO enrollees, which have been compiled by each of the CMO counties. These estimates were developed for purposes of the

CMOs' three-year business plans, and have also been used in the Department's budgeting process for Family Care.

- The appropriate age restrictions were also imposed when pulling these historical waiver eligibility data.
- In order to establish average costs for the two institutional populations (i.e., NF and ICF-MR), eligibility data was extracted directly from the MMIS *for periods of calendar year 1998 institutional stays only*.

2. ____ Base year data is from a **comparable** population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III.

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the UPL for capitated services and the without waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. Also, while it is acceptable to use encounter data or managed care experience to develop with waiver costs or set capitated rates (see Section D.V). At this time, it is not acceptable to use experience data to develop without waiver costs. A workgroup has been formed to examine this policy. This preprint will be updated based upon the outcome of that workgroup.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than the State's MMIS are used.

- One calendar year of cost and eligibility data (1998) has been used throughout these worksheets. The State has also gathered similar data for both calendar years 1997 and 1999. These data can be forwarded very expeditiously, should that prove necessary.

Step 6: See instruction box. This chart should be identical to the chart in Section A.III.d.1.

Step 7: **UPL Adjustments:** On Appendix D.III check all adjustments that apply to base year data.

Step 8. **Fee-For-Service Wraparound Cost Adjustments**: See instruction box.

Preprint Instructions For Steps 7 and 8 above:

Required Adjustments a. through g. (below) and Appendix D.III must be completed by all States. Optional Adjustments a. through l. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if they have made a policy decision to not include that adjustment. If the State has made an adjustment to its without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis, although some (e.g. reinsurance, stop/loss) may be specific to certain contracts and should be noted where appropriate. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this preprint and Appendices D.III and D.IV as necessary to account for the proper methodology used by the State to calculate the UPL.

Describe below the methodology used to develop each adjustment. Prior approval is necessary for methodologies that are not listed as an optional check-off. Please note on each adjustment if the methodology is proprietary to the actuary. Note: HCFA's intent is that if an accepted methodology is used (i.e., is one of the check-offs) and the size of the adjustment is noted in the Appendices and appears reasonable, then no additional documentation would be required for the waiver application. However, the HCFA Regional Office may require more documentation during the UPL and contract rate approval process.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

1. _X_ We assure HCFA that DSH payments are excluded from base year data.
2. _X_ We assure HCFA that DSH payments are excluded from adjustments.

3.___ Other (please describe):

- All hospital services are carved-out from the Family Care benefit. Therefore, the DSH issue does not affect this waiver application.

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

1.___ IBNR adjustment was made. Please indicate the number of years used as basis _____.
   i.___ Claims in base year data source are based on date of service.
   ii.___ Claims in base year data source are based on date of payment.

2._X_ IBNR adjustment was not necessary (Please explain).

- One base year of cost data was used, calendar year 1998. As cost data were pulled in December, 2000, an IBNR adjustment was not required. The claims data were final and complete.

Methodology:

1.___ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.
2.___ Other (please describe):

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.

Basis:

1.___ State historical inflation rates
   (a) Please indicate the years on which the rates are based: Inflation base years_____
   (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
2._X_ Other (please describe):

- Please see the trend letter in Attachment D. Supporting Information submitted by the Department's actuarial firm.

d. Third Party Liability (TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the MCO/PHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and methodology:

1.___ No adjustment was necessary
2._X_ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PHP enrollees
4.___ The State made this adjustment:
5.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PHPs.
6.___ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

1.___ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO/PHP rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid _____. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.
2._X_ Other (please describe):

- This issue is not applicable to the current waiver application: these services are carve-outs from Family Care benefit package.
- The Family Care-enrolled population will only receive these services on a fee-for-service basis. All federally-approved FQHC/RHC payment mechanisms that are currently in place will continue to be employed.
- These historical costs are included in both the 'without waiver' cost calculations and the 'without waiver' cost calculations. (See the "Family Care Carve-Out Services" column of data.) Note that all primary and acute service costs, broadly defined, and including FQHC and RHC expenditures, are reported in this column.
- These costs are *not* included in the capitation rates in the 'with waiver' cost calculations.

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1._X_ Payments outside of the MMIS were made. Those payments include (please describe):

- Community Services Deficit Reduction Benefit program payments have been included in the 'with waiver' cost calculations (i.e., in the capitation rates), as well as in the 'without waiver' cost calculations, in the appropriate column of data.
- Wisconsin Statutes authorize the Wisconsin Medicaid program to make federal matching funds available to counties, tribes, and local health departments through the Community Services Deficit Reduction Benefit (CSDRB) program.
- Under CSDRB, counties, tribes, and local health departments (city, county, or village) are able to claim federal matching dollars to cover approximately 60% of their operating deficits for eligible community services. Public agencies are required to provide 40% match from local funds currently spent on these activities.
- For the purpose of this program, the public agency's operating deficit is the difference between the agency's costs to provide a service and its Medicaid reimbursement for the service. Agencies must annually submit CSDRB cost reports to Wisconsin Medicaid to document their operating deficits.
- Under the CSDRB program, counties, tribes and local health departments may receive additional federal reimbursement for deficits incurred for the following Family Care-covered services: home health services; personal care services; community support programs; case management.

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3.___ The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the

counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.

2._X_ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. Administrative Cost Calculation(Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

1._X_ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to _2_ percent of FFS service costs.

2.___ The State has chosen not to make adjustment.

3.___ Other (please describe):

- The 2% figure is based on information provided by the Medicaid fiscal agent in 1997.
- This figure was used by the Department in setting the 1998 AFDC managed care capitation rates.
- The actual calculation is the total amount of MA administrative expenditures divided by the total amount of MA benefits for State Fiscal Year 1997: $54,000,000 / $2,487,953,000 = 2.17%.

Methodology:

1.___ Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members

2._X_ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.

3.___ Other (please describe):

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

1.___ Claims data used for UPL development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program.
3._X_ The State has chosen not to make adjustment.
4.___ Other (please describe):

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

1.___ The State made this adjustment (please describe):
2._X_ The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services.

1.___ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.
2._X_ The State has chosen not to make adjustment.
3.___ Other (please describe):

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1.____PCCM claims data were used to create capitated UPLs and

management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.

2._X_ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

3.___ Other (please describe):

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1.___ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.

2._X_ The State has chosen not to make adjustment.

3.___ Other (please describe):

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1._X_ Expected State Medicaid FFS fee schedule increases between the base and rate periods.

2.___ The State has chosen not to make FFS price increases in the managed care rates.

3.___ Changes brought about by legal action (please describe):

4._X_ Changes in legislation (please describe):

5.___ Other (please describe):

- The trend calculations done by the Department's actuarial firm take into account changes in Medicaid fees. Please see the trend letter submitted by the Department's actuarial firm, which is attached to this application.
- The calculations carried out by the actuarial firm also take into account a recent pricing change enacted by the Wisconsin Legislature.
- Effective July 1, 2000, 1999 Wisconsin Act 187 increased the hourly Medical Assistance reimbursement rates for workers providing in–home personal care services by $3.25.
- See the 'FY 01' column of the 'MA Rate Increase' table in

Appendix C of the actuarial trend letter submitted with this waiver application; this will show how this legislative change was taken into account in calculating the trend rate. The change was handled similarly for development of the Family Care capitation rates.

- In developing these trends, note that no FFS fee schedule changes were assumed for FY 2002 – FY 2003.

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.

Basis and Methodology:

1.___ The State made this adjustment (please describe).

2._X_ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

Methodology:

1.___ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.

2._X_ The State has chosen not to make adjustment.

3.___ Other (please describe):

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PHPs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides retrospective eligibility back to birth for newborns.

Basis and Methodology:

1.___ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.
2._X_ The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.
3.___ Other (please describe):

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1._X_ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.
2.___ The State has chosen not to make adjustment.
3.___ Other (please describe):

- The trend rate calculated by the Department's actuarial firm takes into account expected changes in utilization.
- See Appendix B of the February 13, 2001, actuarial trend letter submitted with this waiver application. This will show precisely how utilization changes have occurred in the past, and also how utilization is expected to change in the future.

l. Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, HCFA expects states to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:

Step 9: **With Waiver Cost Adjustments** (in addition to the Capitated or FFS Base Year Cost Adjustments), Appendix D.III, Lines 70-72). Note: Costs for the following adjustments are included in the With Waiver Costs Appendix D.V.

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note whether or not the State will be providing reinsurance or stop/loss coverage. Reinsurance may be provided by States to MCOs/PHPs when MCOs/PHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of

services for which the MCO/PHP will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.

Basis and Methodology:

1.___ The State does not provide reinsurance or stop/loss for MCOs/PHPs, but requires MCOs/PHP to purchase such coverage privately. No adjustment was necessary.

2._X_ The State provides reinsurance or stop/loss (please describe):

- The Department has offered the participating CMOs both an aggregate and individual stop-loss option. To date, no CMO has purchased these products. The rates for these products were developed by the Department's actuarial firm.

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs/PHPs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs.

Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PHPs do not exceed the UPL:

c. Other Adjustments (Please list and describe the basis and methodology):

IV. Without Waiver Development: Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in Appendix D.II Member Months.

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated on Appendix D.IV, as illustrated with pharmacy services in the example (Columns Z-AF). If adjusted FFS costs are material, the State should be prepared to explain the adjustments upon request.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix D.V Steps 19-29

The actuarial basis for the capitation rates for both MCOs and PHPs must be specified in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFR 434.61. The capitation rates must be specified in the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO/PHP's cost); and the contractor's community rate with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid

enrollees).

You may use other methods as well. If there are adjustments for stop-loss and reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the UPL.

Finally, as specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL).

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to HCFA:

1._X_ The State assures HCFA that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the rate setting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.
   (a)__ Rates are set at a percent of UPL
   (b)__ Negotiation (please describe):
   (c)__ Experience-based (contractor/State's cost experience or encounter data) (please describe):
   (d)__ Adjusted Community Rate (please describe):
   (e)_X Other (please describe):

2._X_ The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.
   David Ogden, Milliman & Robertson, Inc.

3._X_ The State will submit all capitated rates to the HCFA Regional Office for prior approval.

b.___ The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services.

1.___ The State will be spending a portion of its savings above the capitation rates for additional services under the waiver. Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services_____. This amount must be built into the State's with waiver costs.

2.___ The State is requiring plans to spend a portion of their

capitated rate on additional non-State plan medical services. Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount. In the renewal, please be prepared to document the actual amount spent on non-State plan medical services.

Steps 19-20: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV.

Steps 21-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI

See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs: Appendix D.VII

Steps 30-35: See instruction boxes.

VIII. Cost Effectiveness Summary: Appendix D.VIII

Steps 36-40: See instruction boxes.

Section E. Fraud and Abuse

States can promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PHPs have certain provisions in place. Please check all items below which apply, and describe any other measures the State takes.

I. State Mechanisms

a. _X_ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PHP, by the State's claims processing system).

See Attachment E.I.a. Duplicate Payment Issues

b. _X_ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c. _X_ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

See Attachment E. I. c. Family Care Fraud Protection and Prevention Plan

d. ___ The State has a specific process for informing MCOs/PHPs of fraud and abuse requirements under this waiver. If so, please describe.

e. ___ Other (please describe):

II. MCO/PHP Fraud Provisions

a. _X_ The State ~~requires~~ encourages MCOs/PHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Please describe any required fraud and abuse plan elements.

See Attachment E.I.c. Family Care Fraud Protection and Prevention Plan

b. _X_ The State requires MCOs/PHPs to report suspected fraud and

cooperate with State (including Medicaid Fraud Control Unit) investigations.

Section F. Special Populations

States may wish to refer to the October 1998 HCFA document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

a.___ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/or mental illnesses, Older adults, Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or other. Please describe.

b.___ There are special populations included in this waiver program. Please list the populations.

c.___ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, **please briefly describe**.

d. The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)
2.___ State/local funding sources
3.___ Other (please describe):

e.___ The State has in place a process for ongoing monitoring of its listed special populations included in the waiver in the following areas:

1.___Access to services (please describe):
2.___Quality of Care (please describe):
3.___Coordination of care (please describe):
4.___Enrollee satisfaction (please describe):
5.___Other (please describe):

f.___The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored

g.___The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by population. Please list or attach the standard performance measures and performance improvement projects:

II. State Requirements for MCOs/PHPs

a.___The State has required case management services the MCO/PHP must provide for individuals with special health care needs. Please describe.

b.___As part of its criteria for contracting with an MCO/PHP, the State assesses the MCO/PHP's skill and experience level in accommodating people with special needs.

c.___The State requires MCOs/PHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe.

d.___The State has provisions in contracts with MCOs/PHPs which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If **not** checked, please explain.

e.___The State collects or requires MCOs/PHPs to collect population-specific data for special populations. Please describe.

f.___The State requires MCOs/PHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies

and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only.
2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance.

g.___ The State requires MCOs/PHPs to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions
2.___ The identification of medical procedures to address and/or monitor the conditions.
3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4.___ Other (please describe):

h.___ The State specifies requirements of the MCO/PHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe.

Section G. Complaints, Grievances, and Fair Hearings

MCOs/PHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Social Security Act.

States are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in Subpart E.

I. Definitions:
Please provide definitions used by the State for complaint, grievance, or appeal.

"Complaint" and "Grievance" are defined in Wisconsin Administrative Code ch. HFS 10.13 Definitions as follows:

"(12) 'Complaint' means any communication made to the department, a resource center, a care management organization or a service provider by or on behalf of a client expressing dissatisfaction with any aspect of the operations, activities or behaviors of the department, resource center, care management organization or service provider related to access to or delivery of the family care benefit, regardless of whether the communication requests any remedial action."

"(26) 'Grievance' means a written communication submitted to the department, a county agency, a resource center or a CMO by or on behalf of a client expressing dissatisfaction with any aspect of the decisions, actions, operations, activities, or behaviors of the department, county agency, resource center or CMO that pertain to family care, and requesting that the operations, activities or behaviors be corrected. A grievance may include issues that have not been resolved to the satisfaction of the client through informal means."

II. State Requirements and State Monitoring Activities:

Please check any State requirements and State monitoring activities in effect for MCO/PHP grievance processes.

a. Required Complaints, Grievances, and Fair Hearings Elements:

1. **_X_** The State requires MCO/PHPs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority.

2. **_X_** The MCO/PHP grievance process is approved by the State prior to its implementation.

3. **_X_** An MCO/PHP enrollee can request a State fair hearing under the State's Fair Hearing process. Please explain how, under what circumstances (i.e., direct access or exhaustion), and when an enrollee can access the State Fair Hearing process

Direct access is available at any time with no requirement to exhaust any other procedure for the following issues as specified in Wisconsin Administrative Code ch. HFS 10.55 Fair hearing:

"(1) RIGHT TO FAIR HEARING. Except as limited in subs. (2) to (3), a client has a right to a fair hearing under s. 46.287, Stats. The contested matter may be a decision or action by the department, a resource center, county agency or CMO, or the failure of the department, a resource center, county agency or CMO to act on the contested matter within timeframes specified in this chapter or in the contract with the department. The following matters may be contested through a fair hearing:

(a) Denial of eligibility under s. HFS 10.31 (5) or 10.32 (4).

(b) Determination of cost sharing requirements under s. HFS 10.34.

(c) Determination of entitlement under s. HFS 10.36.

(d) Failure of a CMO to provide timely services and support items that are included in the plan of care.

(e) Reduction of services or support items in the enrollee's individualized service plan, except in accordance with a change agreed to by the enrollee.

(f) An individualized service plan that is unacceptable to the enrollee because any of the following apply:

1. The plan is contrary to an enrollee's wishes insofar as

it requires the enrollee to live in a place that is unacceptable to the enrollee.

2. The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified family care outcomes.

3. The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.

(g) Termination of the family care benefit or involuntary disenrollment from a CMO.

(h) Determinations of protection of income and resources of a couple for maintenance of a community spouse under s. HFS 10.35 to the extent a hearing would be available under s. 49.455 (8) (a), Stats.

(i) Recovery of incorrectly paid family care benefit payments as provided under s. HFS 108.03 (3).

(j) Hardship waivers, as provided in s. HFS 108.02 (12) (e), and placement of liens as provided in ch. HA 3.

(k) Determination of temporary ineligibility for the family care benefit resulting from divestment of assets under s. HFS 10.32 (1) (i).

For issues other than these, exhaustion of the DHFS Review Process is required before accessing the state fair hearing process, as specified in Wisconsin Administrative Code ch. HFS 10.55 Fair hearing:

"HFS 10.55 (2) LIMITED RIGHT TO FAIR HEARING. An enrollee may contest, through fair hearing, any decision, omission or action of a CMO other than those specified under sub. (1) (d) to (f) only if a department review under s. HFS 10.54 has failed to resolve the matter to the satisfaction of the enrollee within the time period specified under s. HFS 10.54 (2)."

Again, contact information for requesting DHFS review is included in member handbooks, as well as an explanation of which issues may go directly to fair hearing.

Members must request a fair hearing in writing within 45 days of an action or failure to act in a timely manner by an Resource Center, Care Management Organization or the Department, as specified in Wisconsin Administrative Code ch. HFS 10.55 Fair hearing.

"HFS 10.55 (3) REQUESTING A FAIR HEARING. A client must request a fair hearing within 45 days after receipt of notice of a decision in a contested matter, or after an Resource Center or CMO has failed to respond within timeframes specified by this chapter or the department. Receipt of notice is presumed within 5 days of the date the notice was mailed. A client must file his or her request for a fair hearing in writing with the division of hearings and appeals in the department of administration. A request is considered filed when received by the division of hearings and appeals. If a client asks the department, a county agency, a Resource Center or CMO for assistance in writing a fair hearing request, the department, Resource Center or CMO must provide that assistance."

4. **_X_** Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

5. **_X_** The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

Note that enrollees may also request continuation of benefits or reinstatement of services during a grievance using the CMO internal grievance procedure or the Department review process for complaints made directly to the Department.

6. **_X_** Enrollees are informed about their complaint, grievance, and fair hearing rights at the time of MCO/PHP enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed.

The CMO member handbook, which is reviewed and approved by the state, includes a description of how members can access the CMOs internal complaint and grievance process, the DHFS review process and the state fair hearing process. These materials are reviewed with enrollees at the time of enrollment by Enrollment Broker staff. CMOs are required to provide enrollee education regarding enrollee rights including complaint and grievance rights within 60 days of enrollment. Information about enrollee rights, the complaint and grievance

processes available to enrollees, the assistance available to enrollees in registering complaints and grievances, and the availability of independent advocacy services is also given to enrollees whenever the CMO takes an adverse action or the enrollee registers a complaint.

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1. **_X_** The internal grievance procedure required by the State is characterized by the following (please check any of the following optional procedures that apply to the State's required grievance procedure):

(a) **_X_** The MCO/PHP governing body approves the grievance procedure and is responsible for the effective operation of the grievance process.

(b) **_X_** The governing body or its delegated grievance committee reviews and resolves complaints and grievances. If the State has any committee composition requirements please list.

The governing board (or designated) committee that reviews and resolves complaints and grievances must contain at least one member or one person who meets the functional level of care for one of the target populations served by the CMO. This person must be free from conflict of interest regarding his or her participation in the governing board/committee.

(c) **_X_** Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

(d) **_X_** Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame

The member must file the grievance or a fair hearing within 45 days of an adverse action or inaction or receipt of written notice from the CMO or the Department (whichever is later).

(e) **_X_** Includes time frames for resolution of grievances for MCO/ PHP grievances. Specify the time frame set by the State

Resolution of a grievance must occur as expeditiously as the member's situation and health condition requires, but no later than 20 days after the CMO receives the grievance. The timeline may be extended an additional 14 days if: a. The member requests the extension; or b. The Department approves the CMO's request for an extension based on a need for more information, and an explanation of how the extension is in the interest of the member.

(f) **_X_** Establishes and maintains an expedited grievance review process for the following reasons: whenever the member's situation and health condition requires
Specify the time frame set by the State for this process: As expeditiously as necessary but no later than 20 days.

(g) **_X_** Permits enrollees to appear before MCO/PHP personnel responsible for resolving the grievance.

(h) **_X_** Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State within a time frame specified by the State. Specify the time frame:

If the CMO makes a decision on a grievance that is entirely or partially adverse to the member, the CMO must submit the decision and all supporting documentation to the Department as expeditiously as the member's situation and health condition requires, but no later than 20 days after the member receives notification of the decision from the standard grievance resolution process.

(i) **_X_** The MCO/PHP acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify:

Within five days of receiving a complaint or grievance, the CMO must acknowledge to the member that the

complaint or grievance has been received, and the expected date of a decision.

(j) **_X_** Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

The CMO must assist members with any steps necessary to resolve a complaint or grievance internally (e.g. assistance in writing, completing forms).

The CMO must allow the member to involve anyone (e.g. significant other, professional advocate, or provider) in the complaint or grievance process. The CMO must provide the member with information on how to contact advocacy agencies. The CMO must also make arrangements with an entity independent of the CMO, at no cost to the CMO or the members, to assist members with a complaint or grievance.

Note: the state also contracts for advocacy services for applicants and enrollees from a contractor that is independent of the DHFS, CMOs Resource Centers or Enrollment Brokers.

(k) **_X_** Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(l) **_X_** If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a ~~physician~~ long term care provider with appropriate expertise in the field of ~~medicine~~ long term care that encompasses the enrollee's disability or condition.

(m) **X** Bases the MCO/PHP's decision on the record of the case and any testimony of the member or others. Note that a member may request a hearing where testimony may be presented.

(n) **_X_** Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

(o) **X** Upon request, provides enrollees and potential enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.

(p) **X** Sets time frames for the MCO/PHP to authorize or provide a service if decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame:

If the CMO reverses a prior decision to deny a service, through the standard grievance resolution process, the CMO must authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than 30 days after the receipt of the reversal.

(q) **X** Informs the enrollee of any applicable mechanism for resolving the issue external to the MCOs/PHPs own processes.

A member can submit a complaint or grievance directly to the Department before, during or after using the internal CMO complaint/grievance process. This process is in addition to the fair hearing process described under G II a 3 above, which can also be accessed at any time for most kinds of complaints. There is no requirement to exhaust the internal CMO procedure before proceeding to either of these processes.

(r) ___ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

(s) **X** Other (please explain):

The state has contracted with an organization that is independent of CMOs, Resource Centers or Enrollment Brokers to provide individual enrollees with advocacy services to assist with complaints and grievances.

2. _X_ MCOs/PHPs maintain a log of all complaints and grievances and their resolution.

3. _X_ MCOs/PHPs send the State a summary of complaints and grievances on at least an annual basis.

4) _X_ The State requires MCOs/PHPs to maintain, aggregate, and analyze information on the nature of issues raised by enrollees and on their resolution.

5) _X_ The State requires MCOs/PHPs to conduct in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.

6. _X_ The State and/or MCO/PHP have ombudsprograms to assist enrollees in the complaint, grievance, and fair hearing process.

The state has contracted with an organization that is independent of CMOs, Resource Centers or Enrollment Brokers to provide individual enrollees with advocacy services to assist with complaints and grievances.

7. ___ Other (please specify):

Section H. Enrollee Information and Rights

This section describes the process for informing enrollees and potential enrollees receive about the waiver program, and protecting their rights once enrolled. The information in this section (e.g., enrollee handbooks, enrollment information, PCP choice materials) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.III.a).

I. Enrollee Information - Understandable to Enrollees:

This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items which apply to the State or MCO/PHP. Items which are required have A[Required]≅ in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. _X_ [Required] The State will ensure that enrollee materials provided to enrollees by the State, the enrollment broker, and the MCO/PHP are clear and easily understandable.

b. _X_ Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):
Spanish, Hmong, Russian, Vietnamese as appropriate

The State has chosen these languages because (check any that apply):

1. **_X_** The languages comprise all prevalent languages in the state.

2. **___** The languages comprise all languages in the MCO/PHP service area spoken by approximately ___ percent or more of the population.

3. **____** Other (please explain):

c. _X_ Program information is available and understandable to non-English speaking enrollees whose language needs are not met through the provision of translated material described above. **Please describe.**

The CMO must provide materials in formats accessible due to language spoken and various impairments, including but not limited to Braille and large print. Materials shared with potential members and members' family must be understandable in a language and format based on the following:

- Material directed at a specific member (e.g. written communication of intention to deny a service): must be in the language understood by the individual.

- Material directed at potential members or members in general (e.g. member handbook): must be provided in languages prevalent in the CMO service area, and in accessible formats (e.g. Braille, large print).

- All materials: must be in easily understood language and format. Materials must take into account individuals with limited reading proficiency.

- The CMO must provide instructions to members and potential members in the materials on how to obtain information in the appropriate language or accessible format (e.g. sign language) and how to access such translation/interpreter services.

d. _X_ Required] Translation services are available to all enrollees, regardless of languages.

e. _X_ Every new enrollee will have access to a toll-free number to call for questions.

II. Enrollee Information - Content

This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provides the following information to enrollees and potential enrollees.

1**. _X_** Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2**. _X_** An initial notification letter

3**. _X_** Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

4. **_X_** A form for enrollment in the waiver program and selection of a plan

5. **_X_** A list of plans serving the enrollee's geographical area

6. **_X_** Comparative information about plans

7. **_X_** Information on how to obtain counseling on choice of MCOs/PHPs

8. **_X_** Detailed provider network listings

9. **_X_** A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

   Enrollees who are MA-eligible will be issued an MA "Forward Card", which informs providers of eligibility status when swiped in a reader. Fee-for-service providers are advised to check the member's eligibility status using either this card swipe system, or the Department's Automated Voice Response (AVR) system, or Direct Information Access Line with Updates for Providers (Dial-Up). In each method, the provider is informed of the member's eligibility status through the Department's Eligibility Verification System (EVS).

   CMOs may also issue both MA enrollees and non-MA enrollees some other card for use with network providers.

10. **___** A health risk assessment form to identify conditions requiring immediate attention.

11. **___** Information concerning the availability of special services, expertise, and experience offered by MCO/PHPs and providers

12. **_X_** [Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

13. **na** [Required for MCOs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5) Family Care has no lock-in period)

14. **X** [Required for MCOs] Information on how to obtain services not covered by the MCO/PHP but covered under the State plan.

15. **na** [Required for MCOs] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change MCOs/PHPs (See A.III.b.5) Family Care has no lock-in period)

16. ___ Other items (please explain):

b. Information provided by the MCO/PHP The State requires the MCO/PHP to provide, written information on the following items to enrollees and potential enrollees. Unless otherwise noted, required items must be provided upon actual enrollment into the MCO/PHP (the BBA requires some information be provided only upon request). Please check all that apply.

1. **X** [MCOs required to provide upon request] Enrollee rights.

2. **X** [MCOs required to provide upon request] Enrollee responsibilities.

3. **X** [MCOs required to provide upon request] Names, locations, qualifications and availability of network providers, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among network providers.

4. **X** [MCOs required to provide upon request] Amount, duration and scope of all benefits (included and excluded).

5. **na** [MCOs required to provide upon request] Physician incentive program, including (1) if the MCO has a PIP that covers referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of survey results, if a survey is required.

6. **na** [Required for MCOs] The MCO enrollee materials (either through the enrollee handbook, semi-annual or annual open enrollment materials, or by some other means) annually disclose to enrollees their right to adequate and timely information related to physician incentives.

7. **X** [MCOs and PHPs required to provide upon request *and* upon

enrollment] Information explaining the complaints and grievance procedures for resolving enrollee issues, including issues relating to authorization of, coverage of, or payment for services.

8. **X** [Required for MCOs] Procedures for obtaining services, including authorization requirements.

9. **X** [Required for MCOs] After-hours ~~and emergency~~ coverage (emergency services are carved out). The State ensures enrollee access to emergency services by requiring the MCO to provide the following information to all enrollees [note: these items are required of MCOs only; however, please fill in if applicable for PHPs]:

   i. **X** the right to use participating and non-participating providers

   ii. **na** definition of emergency services

   iii. **na** the prudent layperson definition of emergency medical condition

   iv. **na** the prohibition on retrospective denials for services that meet the prudent layperson definitions (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)

   v. **na** the right to access emergency services without prior authorization

10. **X** [Required for MCOs] Procedures for obtaining non-covered or out-of-area services.

11. **na** [Required for MCOs] Any special conditions or charges that may apply to obtaining services.

12. **X** [Required for MCOs and PHPs] The right to obtain family planning services from any Medicaid-participating provider

13. **na** [Required for MCOs] Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider.

14. X [Required for MCOs] Charges to enrollees, if applicable.

15. na [Required for MCOs] Procedures for changing primary care providers.

16. X Procedures for obtaining mental health, substance abuse, and developmental disability services.

17. X Procedures for recommending changes in policies or services.

18. X The covered service area.

19. X Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

20. ___ A description of new technology for inclusion of a covered benefit.

21. ___ Enrollees' right to obtain information about the MCO/PHP, including information standards, utilization control procedures and the financial condition of the organization.

22. ___ Other (please describe):

III. Enrollee Rights:

Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PHPs protect enrollee rights. The State requires MCOs/PHPs to:

a. X Have written policies with respect to enrollee rights.

b. X Communicate policies to enrollees, staff and providers.

c. X Monitor and promote compliance with their policies by staff and providers.

d. X Ensure compliance with Federal and State laws affecting the rights of enrollees such as all Civil rights and anti-discrimination laws.

e. X Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f. X Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g. X Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

h. na Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

i. X Ensure that each enrollee has the right to refuse care from specific providers.

j. X Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

k. X Comply with requirements of Federal and State law with respect to advance directives.

l. X Have specific written policies that allow enrollees to receive Information on available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

m. na Allow direct access to medical specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

Medical specialists are carved out of Family Care.

n. Other (please describe):

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a. X The State tracks disenrollments and reasons for disenrollments or requires MCOs/PHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b. X The State will approve enrollee information prior to its release by the MCO/PHP.

c. X The State will monitor MCO/PHP enrollee materials for compliance in

the following manner (please describe):

The state reviews and approves all member enrollee materials prior to contracting and before a contract is renewed. State staff verifies the accuracy of benefit information by checking CMO materials against tools that are contained in Attachment A.III. Program Impact: Marketing Review Tools. The verification process includes reviewing that certain information, such as explanations and appeal rights are accurate. The state also provides guidance for both developing and reviewing enrollee materials through its technical assistance guidelines and contract interpretation bulletins.

d. X The State will monitor the MCO/PHPs compliance with the enrollee rights provisions in the following manner (please describe):

Materials describing enrollee rights are approved as part of the state review and approval of member handbooks. Information about enrollee rights, the complaint and grievance processes available to enrollees, the assistance available to enrollees in registering complaints and grievances, and the availability of independent advocacy services is also given to enrollees whenever the CMO takes an adverse action or the enrollee registers a complaint. Compliance with enrollee rights provisions will be monitored through quality assurance monitoring and through analysis of complaints or grievances, requests to change providers or case managers, member satisfaction surveys, and disenrollment reasons.

Section I. Resource Guide

Below are references which provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

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Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

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Collecting and Analyzing Medicaid Managed Care Data, 1997.
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Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

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U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health

Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.
U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: AManaging Managed Care: Quality Improvement in Behavioral Health.≅*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, AAn Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies.≅*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, AAn Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders.≅*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, ATechnical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers.≅*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.